

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05229

5254

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center</u> <u>National Institutes of Health, Bethesda</u>				d. STREET ADDRESS <u>103 North Van Buren Street</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Battaile</u> Last <u>Allnutt</u>				4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>19 56</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>26 April 1887</u>			
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>6</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. <u></u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>(Retired)</u>					
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Henry C. Allnutt</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Viers</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Not available</u>					
17. INFORMANT Address <u>The Medical Record, Clinical Center, NIH</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> <u>190X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Melanoma to the Liver</u> DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>April 17, 1956</u> , to <u>May 2, 1956</u> , that I last saw the deceased alive on <u>May 2, 1956</u> , and that death occurred at <u>10, 25 P.M.</u> from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <u>The Clinical Center</u>				DATE SIGNED <u>5/3/56</u>					
ACTUAL SIGNATURE <u>J. L. Fahey</u> M.D.									
PHYSICIAN'S NAME (Type) <u>John L. Fahey, M.D.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/5/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.</u>				24a. REC'D BY REGISTRAR <u>6-7-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

9

**BUREAU V.**

MAY 9 1956

RECEIVED

112.00

near U.S./Mex. co.

01/03/96

1011

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Medical Examiner (Dr. Blossford) notified & he - O.K. & my issuing this certificate for

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5232

CERTIFICATE OF DEATH

05230

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7620 MAPLE AVENUE</b>		d. STREET ADDRESS <b>7620 MAPLE AVENUE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES GARNET GORDON BAILEY</b>		4. DATE OF DEATH Month Day Year <b>MAY 27 1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 4, 1890</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK, GOV'T. ACCOUNTING OFFICE, U.S. GOV'T.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>T. HAYS, KANSAS</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALFRED D. BAILEY</b>		14. MOTHER'S MAIDEN NAME <b>MARY GORDON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW #1</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. WALTER B. HARGETT, 4325 Claggett Rd. University Park, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>430.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Heart Disease</b> DUE TO (c) <b>16 years</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 21, 1940</b> , to <b>May 27, 1956</b> , that I last saw the deceased alive on <b>Apr. 10, 1956</b> , and that death occurred at <b>5:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9241 Col. Blvd. Silver Spring, Md.</b> DATE SIGNED <b>5/27/56</b> ACTUAL SIGNATURE <b>J. Marion Bankhead</b> M.D. PHYSICIAN'S NAME (Type) <b>J. Marion Bankhead, Silver Spring, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/29/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEORGE COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>		ADDRESS <b>SILVER SPRING, MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>5/29/56</b>		24b. REGISTRAR'S SIGNATURE <b>J. Marion Bankhead</b>	

BUREAU V. S.

MAY 31 1956

RECEIVED



## CERTIFICATE OF DEATH

Reg. Dist. No. 216

5255

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>chevy chase</u>	
c. LENGTH OF STAY IN 1b <u>6 hrs.</u>		d. STREET ADDRESS <u>1 Quincy Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>NANNIE Bell BAILEY</u>		4. DATE OF DEATH Month Day Year <u>5 - 26 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27 1897</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MAJOR MARSHALL</u>		14. MOTHER'S MAIDEN NAME <u>LAURA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>SUSIE BAILEY (Daughter)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolus</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>6 hours</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 25, 1956</u> , to <u>May 25, 1956</u> , that I last saw the deceased alive on <u>May 25, 1956</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Sharpe</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>10644 Connecticut Ave 5-26-56</u>	
PHYSICIAN'S NAME (Type) <u>George Sharpe</u>		<u>Kensington, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/1/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat.</u>		22d. LOCATION (City, town, or county) (State) <u>Fort Myer Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Ernest Jarvis Co.</u> ADDRESS <u>1432 You St. NW</u>		24a. REC'D BY REGISTRAR DATE <u>6/1/56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Horn</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5256  
CERTIFICATE OF DEATH

05232  
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <b>District of Columbia</b> COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>31 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Clinical Center</b>				d. STREET ADDRESS <b>1110 49th Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Susie Elmira Baylis</b>				4. DATE OF DEATH <b>May 10, 1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 13, 1897</b>		9. AGE (In years last birthday) <b>59 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Household duties</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Gillison Wanser</b>				14. MOTHER'S MAIDEN NAME <b>Annie Gaskins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myasthenia Gravis</b> <b>195X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Neoplasm of thyroid gland</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Hour a. <b>11</b> Month, <b>19</b> Day, <b>19</b> Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 9, 1956</b> , to <b>May 10, 1956</b> , that I last saw the deceased alive on <b>May 10, 1956</b> , and that death occurred at <b>5 A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Glenn A. Drager</b>		M.D. <b>The Clinical Center</b>		DATE SIGNED <b>May 10, 1956</b>			
PHYSICIAN'S NAME (Type) <b>Glenn A. Drager,</b>		ADDRESS (Street, city or town, state) <b>The National Institutes of Health Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>5/12/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dudew Funeral Home</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>5/16/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary Farrelly</b>			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18  
 CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES J. JONES		31		M		W		1885		MASSACHUSETTS		BOSTON		UNITED STATES	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1910		MASSACHUSETTS		BOSTON		UNITED STATES		MAY 16 1956		BOSTON		MASSACHUSETTS	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
HEART DISEASE		NATURAL		MASSACHUSETTS		BOSTON		UNITED STATES		MAY 16 1956		BOSTON		MASSACHUSETTS	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		COUNTRY		DATE		PLACE		CITY	
JAMES J. JONES		MAY 16 1956		MASSACHUSETTS		BOSTON		UNITED STATES		MAY 16 1956		BOSTON		MASSACHUSETTS	
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		COUNTRY		DATE		PLACE		CITY	
JAMES J. JONES		MAY 16 1956		MASSACHUSETTS		BOSTON		UNITED STATES		MAY 16 1956		BOSTON		MASSACHUSETTS	

RECEIVED  
 MAY 16 1956  
 BUREAU V. S.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18  
 CERTIFICATE OF DEATH

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>SILVER SPRING</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>McCENEY AVENUE, BURNT MILLS HILLS</b>		d. STREET ADDRESS <b>McCENEY AVENUE, BURNT MILLS HILLS</b>	
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>VERNON</b> Last <b>BETTERS</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>12</b> Year <b>19 56</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/19/06</b>
9. AGE (in years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive Vice-Pres. U.S. Conference of Mayors</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MORRIS, MINNESOTA</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BURT BETTERS</b>		14. MOTHER'S MAIDEN NAME <b>OLIVIA CHRISTENSEN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW #2</b>		16. SOCIAL SECURITY NO. <b>WW #2</b>	
17. INFORMANT <b>MRS. MYRA K. BETTERS, McCeney Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary occlusion</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschait</b>		DATE SIGNED <b>5-12-56</b>	
EXAMINER'S NAME (Type) <b>FRANK J. Broschait</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	22b. DATE THEREOF <b>5/12/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CREMATORY</b>	22d. LOCATION (City, town, or county) (State) <b>PRINCE GEORGE COUNTY, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>		24a. REC'D BY REGISTRAR DATE <b>5/15/56</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Francis Peter</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any de-  
 cede the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be  
 forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-permit permit. File pages 1 and 2 with the registrar prior to burial, cremation,  
 or removal.



RECEIVED  
MAY 18 1956  
BUREAU V. S.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [REDACTED]  
2. SEX: [REDACTED]  
3. AGE: [REDACTED]  
4. DATE OF BIRTH: [REDACTED]  
5. PLACE OF BIRTH: [REDACTED]  
6. OCCUPATION: [REDACTED]  
7. CAUSE OF DEATH: [REDACTED]  
8. MANNER OF DEATH: [REDACTED]  
9. SIGNATURE OF MEDICAL EXAMINER: [REDACTED]  
10. DATE OF EXAMINATION: [REDACTED]

11. SIGNATURE OF REGISTRAR: [REDACTED]  
12. DATE OF REGISTRATION: [REDACTED]

13. SIGNATURE OF CLERK: [REDACTED]  
14. DATE OF ENTRY: [REDACTED]

15. SIGNATURE OF ASSISTANT CLERK: [REDACTED]  
16. DATE OF ENTRY: [REDACTED]

17. SIGNATURE OF CHIEF CLERK: [REDACTED]  
18. DATE OF ENTRY: [REDACTED]

19. SIGNATURE OF DEPUTY CHIEF CLERK: [REDACTED]  
20. DATE OF ENTRY: [REDACTED]

21. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK: [REDACTED]  
22. DATE OF ENTRY: [REDACTED]

23. SIGNATURE OF CLERK IN CHARGE: [REDACTED]  
24. DATE OF ENTRY: [REDACTED]

25. SIGNATURE OF CLERK: [REDACTED]  
26. DATE OF ENTRY: [REDACTED]

27. SIGNATURE OF CLERK: [REDACTED]  
28. DATE OF ENTRY: [REDACTED]

29. SIGNATURE OF CLERK: [REDACTED]  
30. DATE OF ENTRY: [REDACTED]

31. SIGNATURE OF CLERK: [REDACTED]  
32. DATE OF ENTRY: [REDACTED]

33. SIGNATURE OF CLERK: [REDACTED]  
34. DATE OF ENTRY: [REDACTED]

35. SIGNATURE OF CLERK: [REDACTED]  
36. DATE OF ENTRY: [REDACTED]

37. SIGNATURE OF CLERK: [REDACTED]  
38. DATE OF ENTRY: [REDACTED]

39. SIGNATURE OF CLERK: [REDACTED]  
40. DATE OF ENTRY: [REDACTED]

41. SIGNATURE OF CLERK: [REDACTED]  
42. DATE OF ENTRY: [REDACTED]

43. SIGNATURE OF CLERK: [REDACTED]  
44. DATE OF ENTRY: [REDACTED]

45. SIGNATURE OF CLERK: [REDACTED]  
46. DATE OF ENTRY: [REDACTED]

47. SIGNATURE OF CLERK: [REDACTED]  
48. DATE OF ENTRY: [REDACTED]

49. SIGNATURE OF CLERK: [REDACTED]  
50. DATE OF ENTRY: [REDACTED]

51. SIGNATURE OF CLERK: [REDACTED]  
52. DATE OF ENTRY: [REDACTED]

53. SIGNATURE OF CLERK: [REDACTED]  
54. DATE OF ENTRY: [REDACTED]

55. SIGNATURE OF CLERK: [REDACTED]  
56. DATE OF ENTRY: [REDACTED]

57. SIGNATURE OF CLERK: [REDACTED]  
58. DATE OF ENTRY: [REDACTED]

59. SIGNATURE OF CLERK: [REDACTED]  
60. DATE OF ENTRY: [REDACTED]

61. SIGNATURE OF CLERK: [REDACTED]  
62. DATE OF ENTRY: [REDACTED]

63. SIGNATURE OF CLERK: [REDACTED]  
64. DATE OF ENTRY: [REDACTED]

65. SIGNATURE OF CLERK: [REDACTED]  
66. DATE OF ENTRY: [REDACTED]

67. SIGNATURE OF CLERK: [REDACTED]  
68. DATE OF ENTRY: [REDACTED]

69. SIGNATURE OF CLERK: [REDACTED]  
70. DATE OF ENTRY: [REDACTED]

71. SIGNATURE OF CLERK: [REDACTED]  
72. DATE OF ENTRY: [REDACTED]

73. SIGNATURE OF CLERK: [REDACTED]  
74. DATE OF ENTRY: [REDACTED]

75. SIGNATURE OF CLERK: [REDACTED]  
76. DATE OF ENTRY: [REDACTED]

77. SIGNATURE OF CLERK: [REDACTED]  
78. DATE OF ENTRY: [REDACTED]

79. SIGNATURE OF CLERK: [REDACTED]  
80. DATE OF ENTRY: [REDACTED]

81. SIGNATURE OF CLERK: [REDACTED]  
82. DATE OF ENTRY: [REDACTED]

83. SIGNATURE OF CLERK: [REDACTED]  
84. DATE OF ENTRY: [REDACTED]

85. SIGNATURE OF CLERK: [REDACTED]  
86. DATE OF ENTRY: [REDACTED]

87. SIGNATURE OF CLERK: [REDACTED]  
88. DATE OF ENTRY: [REDACTED]

89. SIGNATURE OF CLERK: [REDACTED]  
90. DATE OF ENTRY: [REDACTED]

91. SIGNATURE OF CLERK: [REDACTED]  
92. DATE OF ENTRY: [REDACTED]

93. SIGNATURE OF CLERK: [REDACTED]  
94. DATE OF ENTRY: [REDACTED]

95. SIGNATURE OF CLERK: [REDACTED]  
96. DATE OF ENTRY: [REDACTED]

97. SIGNATURE OF CLERK: [REDACTED]  
98. DATE OF ENTRY: [REDACTED]

99. SIGNATURE OF CLERK: [REDACTED]  
100. DATE OF ENTRY: [REDACTED]

5258

## CERTIFICATE OF DEATH

Reg. Dist. No. 276

05234

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Alabama</b> b. COUNTY <b>40X-3</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sumiton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>		d. STREET ADDRESS <b>none</b>	
3. NAME OF DECEASED (Type or print) First <b>Myrna</b> Middle <b>Loy</b> Last <b>Blackston</b>		4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 16, 1955</b>
9. AGE (In years last birthday) yrs. <b>10</b> Months <b>21</b> Days <b>21</b> Hours <b>Min.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>child</b>	
11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jesse Blackston</b>		14. MOTHER'S MAIDEN NAME <b>Leota Hagood</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Heart Failure</b> DUE TO <b>7540</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congenital Heart Disease - Tetralogy of Fallot</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anemia secondary to decreased iron intake - food.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 6, 19 56</b> , to <b>May 7, 19 56</b> , that I last saw the deceased alive on <b>May 7, 19 56</b> , and that death occurred at <b>12:50P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Edward H Sharp</b>		M.D. <b>The Clinical Center</b>	
PHYSICIAN'S NAME (Type) <b>Edward H. Sharp, M.D.</b>		<b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>5/8/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Carbon Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Birmingham, Alabama</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>2901 14th St., N.W.</b> <b>Washington 9, D.C.</b>	24b. REGISTRAR'S SIGNATURE <b>Bevin M. Thompson</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• **2008**

2

BUREAU V. S.

MAY 11 1956

RECEIVED

5259

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTG.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8901 Brookeville Rd</b>		d. STREET ADDRESS <b>8901 BROOKEVILLE Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>FANNIE FRANCES BRADLEY</b>		4. DATE OF DEATH <b>MAY 4 1956</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 14 1879</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Prince William Co. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Fisher</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Hanes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mrs. Gady Thomas</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442x</b> <b>Uraemia</b> DUE TO <b>Hypertensive Cardio Renal Disease with Edema</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <b>Hypertensive Cardio Renal Disease with Edema</b> (c) <b>Disease with Edema</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>12</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 12 1948</b> to <b>May 4 56</b> , that I last saw the deceased alive on <b>May 3 1956</b> , and that death occurred at <b>10:47 M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Webster Sewell</b> M.D.		ADDRESS (Street, city or town, state) <b>Norbeck Rd 1 Silver Spring Md.</b>	
PHYSICIAN'S NAME (Type) <b>WEBSTER SEWELL</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>5-9-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Silver Spring Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nancy Washington</b>		ADDRESS <b>467 N st N. W</b>	
24a. REC'D BY REGISTRAR <b>DATE 5-10-56</b>		24b. REGISTRAR'S SIGNATURE <b>Frances Patterson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

8280

8901 BRACKENRIDGE ST  
SILVER SPRING MD  
MAY 1951

8901 BRACKENRIDGE ST  
SILVER SPRING MD  
MAY 1951

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BUREAU V. S.

MAY 11 1951

RECEIVED



## CERTIFICATE OF DEATH

Reg. Dist. No.

217

5260

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>28 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL Silver Spring</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Montgomery County General Hospital</b>				d. STREET ADDRESS <b>Rt. #1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Maurice</b> Middle <b>Bready</b> Last <b>Bready</b>				4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/18/67</b>		9. AGE (In years last birthday) <b>88</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming-Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Bready</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Baer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Record</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis</b> <b>593X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Nephritis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4/25/56</b> <b>years</b> <b>days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/1/56</b> , 19 <b>56</b> , to <b>5/2/56</b> , 19 <b>56</b> that I last saw the deceased alive on <b>5/1/56</b> , 19 <b>56</b> , and that death occurred at <b>10:25 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>J. W. Bird</b> M.D.				DATE SIGNED <b>5/3/56</b>			
PHYSICIAN'S NAME (Type) <b>J. W. Bird, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-5-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Union</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>5-4-56</b>		24b. REGISTRAR'S SIGNATURE <b>Katherine B. Lawler</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO THE CLERK OF THE COURT OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information required by the law, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5261

CERTIFICATE OF DEATH

05237

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>74 Suburban</i>		d. STREET ADDRESS <i>4827 Leland St.</i>	
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Alexander</i> Last <i>Brightwell</i>		4. DATE OF DEATH Month <i>MAY</i> Day <i>11</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>NOV. 21, 1884</i>
9. AGE (In years, last birthday) <i>71</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Private Enterprise</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John W. Brightwell</i>		14. MOTHER'S MAIDEN NAME <i>Matilda McCormick</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Un-known</i>	
17. INFORMANT <i>Elizabeth Schaefer</i>		Address <i>4827 Leland St. Chevy Chase, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Myocardial Infarction</i> DUE TO (b) <i>Coronary Arteriosclerosis</i> DUE TO (c) <i>Arteriosclerosis Hypertension</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>JUNE</i> , 19 <i>50</i> , to <i>5-11</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>5-11</i> , 19 <i>56</i> , and that death occurred at <i>6:25 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>P.P. Andrews</i>		ADDRESS (Street, city or town, state) <i>4201 Essenden St. N.W. Washington, D.C.</i>	
PHYSICIAN'S NAME (Type) <i>P.P. ANDREWS</i>		DATE SIGNED <i>5-11-56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-14-1956</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Georges Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		24. REC'D BY REGISTRAR <i>5-11-56</i>	
24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. PLACE OF BIRTH <i>John Doe</i>		5. DATE OF BIRTH <i>1910</i>		6. PLACE OF DEATH <i>John Doe</i>	
7. OCCUPATION <i>John Doe</i>		8. CAUSE OF DEATH <i>John Doe</i>		9. MANNER OF DEATH <i>John Doe</i>	
10. SIGNATURE OF PHYSICIAN <i>John Doe</i>		11. SIGNATURE OF CORONER <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. DATE OF DEATH <i>John Doe</i>		14. TIME OF DEATH <i>John Doe</i>		15. PLACE OF BURIAL <i>John Doe</i>	
16. NAME OF FUNERAL HOME <i>John Doe</i>		17. NAME OF MINISTER <i>John Doe</i>		18. NAME OF CHURCH <i>John Doe</i>	
19. NAME OF CEMETERY <i>John Doe</i>		20. NAME OF INTERVIEWER <i>John Doe</i>		21. NAME OF REPORTER <i>John Doe</i>	
22. NAME OF REGISTRAR <i>John Doe</i>		23. NAME OF CLERK <i>John Doe</i>		24. NAME OF ASSISTANT <i>John Doe</i>	
25. NAME OF ATTENDING PHYSICIAN <i>John Doe</i>		26. NAME OF SURGEON <i>John Doe</i>		27. NAME OF DENTIST <i>John Doe</i>	
28. NAME OF VETERINARIAN <i>John Doe</i>		29. NAME OF MIDWIFE <i>John Doe</i>		30. NAME OF NURSE <i>John Doe</i>	
31. NAME OF PHARMACEUTICAL <i>John Doe</i>		32. NAME OF LABORATORY <i>John Doe</i>		33. NAME OF X-RAY <i>John Doe</i>	
34. NAME OF PATHOLOGIST <i>John Doe</i>		35. NAME OF ANATOMIST <i>John Doe</i>		36. NAME OF HISTOLOGIST <i>John Doe</i>	
37. NAME OF MICROSCOPIST <i>John Doe</i>		38. NAME OF RADIOLOGIST <i>John Doe</i>		39. NAME OF RADIOLOGIST <i>John Doe</i>	
40. NAME OF RADIOLOGIST <i>John Doe</i>		41. NAME OF RADIOLOGIST <i>John Doe</i>		42. NAME OF RADIOLOGIST <i>John Doe</i>	
43. NAME OF RADIOLOGIST <i>John Doe</i>		44. NAME OF RADIOLOGIST <i>John Doe</i>		45. NAME OF RADIOLOGIST <i>John Doe</i>	
46. NAME OF RADIOLOGIST <i>John Doe</i>		47. NAME OF RADIOLOGIST <i>John Doe</i>		48. NAME OF RADIOLOGIST <i>John Doe</i>	
49. NAME OF RADIOLOGIST <i>John Doe</i>		50. NAME OF RADIOLOGIST <i>John Doe</i>		51. NAME OF RADIOLOGIST <i>John Doe</i>	
52. NAME OF RADIOLOGIST <i>John Doe</i>		53. NAME OF RADIOLOGIST <i>John Doe</i>		54. NAME OF RADIOLOGIST <i>John Doe</i>	
55. NAME OF RADIOLOGIST <i>John Doe</i>		56. NAME OF RADIOLOGIST <i>John Doe</i>		57. NAME OF RADIOLOGIST <i>John Doe</i>	
58. NAME OF RADIOLOGIST <i>John Doe</i>		59. NAME OF RADIOLOGIST <i>John Doe</i>		60. NAME OF RADIOLOGIST <i>John Doe</i>	
61. NAME OF RADIOLOGIST <i>John Doe</i>		62. NAME OF RADIOLOGIST <i>John Doe</i>		63. NAME OF RADIOLOGIST <i>John Doe</i>	
64. NAME OF RADIOLOGIST <i>John Doe</i>		65. NAME OF RADIOLOGIST <i>John Doe</i>		66. NAME OF RADIOLOGIST <i>John Doe</i>	
67. NAME OF RADIOLOGIST <i>John Doe</i>		68. NAME OF RADIOLOGIST <i>John Doe</i>		69. NAME OF RADIOLOGIST <i>John Doe</i>	
70. NAME OF RADIOLOGIST <i>John Doe</i>		71. NAME OF RADIOLOGIST <i>John Doe</i>		72. NAME OF RADIOLOGIST <i>John Doe</i>	
73. NAME OF RADIOLOGIST <i>John Doe</i>		74. NAME OF RADIOLOGIST <i>John Doe</i>		75. NAME OF RADIOLOGIST <i>John Doe</i>	
76. NAME OF RADIOLOGIST <i>John Doe</i>		77. NAME OF RADIOLOGIST <i>John Doe</i>		78. NAME OF RADIOLOGIST <i>John Doe</i>	
79. NAME OF RADIOLOGIST <i>John Doe</i>		80. NAME OF RADIOLOGIST <i>John Doe</i>		81. NAME OF RADIOLOGIST <i>John Doe</i>	
82. NAME OF RADIOLOGIST <i>John Doe</i>		83. NAME OF RADIOLOGIST <i>John Doe</i>		84. NAME OF RADIOLOGIST <i>John Doe</i>	
85. NAME OF RADIOLOGIST <i>John Doe</i>		86. NAME OF RADIOLOGIST <i>John Doe</i>		87. NAME OF RADIOLOGIST <i>John Doe</i>	
88. NAME OF RADIOLOGIST <i>John Doe</i>		89. NAME OF RADIOLOGIST <i>John Doe</i>		90. NAME OF RADIOLOGIST <i>John Doe</i>	
91. NAME OF RADIOLOGIST <i>John Doe</i>		92. NAME OF RADIOLOGIST <i>John Doe</i>		93. NAME OF RADIOLOGIST <i>John Doe</i>	
94. NAME OF RADIOLOGIST <i>John Doe</i>		95. NAME OF RADIOLOGIST <i>John Doe</i>		96. NAME OF RADIOLOGIST <i>John Doe</i>	
97. NAME OF RADIOLOGIST <i>John Doe</i>		98. NAME OF RADIOLOGIST <i>John Doe</i>		99. NAME OF RADIOLOGIST <i>John Doe</i>	
100. NAME OF RADIOLOGIST <i>John Doe</i>		101. NAME OF RADIOLOGIST <i>John Doe</i>		102. NAME OF RADIOLOGIST <i>John Doe</i>	

BUREAU V. 1

MAY 15 1956

RECEIVED

5262

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>1 week</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County Gen. Hosp.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Samuel V. Broadhurst</b>				4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 10, 1866</b>	9. AGE (In years lost birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operated threshing machines</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Penn.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>George A. Broadhurst</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Snowden</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Cramwell King, Gaithersburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Arteriosclerotic Heart Disease</b> DUE TO <b>with congestive heart failure +</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>myocardial infarction</b> DUE TO (c) <b>Coronary Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>10 days</b> <b>5 days</b> <b>11 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>The accident</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While _____ at work <input type="checkbox"/> Not while _____ at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>July 7, 1953</b> to <b>May 21, 1956</b> , that I last saw the deceased alive on <b>May 20, 1956</b> , and that death occurred at <b>7:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>M. McKendree Boyer, M.D.</b> <b>Damascus, Md.</b> PHYSICIAN'S NAME (Type) <b>M. McKendree Boyer, M.D.</b> <b>Damascus, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 23, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bethesda</b>		22d. LOCATION (City, town, or county) (State) <b>Brownsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Molanworth</b>				ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>5-23-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bertine B Lawler</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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Mr. Cramwell King, California

None

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05239

5263

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>44 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. STREET ADDRESS <b>9616 51st Place</b>	
3. NAME OF DECEASED (Type or print) First <b>Anthony</b> Middle <b>William</b> Last <b>Brown</b>		4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 23, 1953</b>
9. AGE (In years last birthday) <b>2</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Brown</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Moss</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>brain abscess</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>acute leukemia</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 2</b> , 19 <b>56</b> , to <b>May 16</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>May 16</b> , 19 <b>56</b> , and that death occurred at <b>12:10</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>May 16, 1956</b> ACTUAL SIGNATURE <b>Mehran Goulian</b> M.D. <b>National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>Mehran Goulian, M.D.</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/17/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Spartanburg, S.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co., Silverdale, Md.</b>		24. REC'D BY REGISTRAR DATE <b>MAY 22 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5264

CERTIFICATE OF DEATH

05240

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt #1 Clarksburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Clinical Center, NIH</u>				d. STREET ADDRESS <u>Rt #1</u>			
3. NAME OF DECEASED (Type or print) <u>James Walter Cabell</u>				4. DATE OF DEATH <u>5</u> <u>19</u> <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1946</u>	9. AGE (In years last birthday) <u>9</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>  </u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Cabell</u>				14. MOTHER'S MAIDEN NAME <u>MATTIE L Smith.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>  </u>				Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Naso pharynx &amp; extension to Left Maxilla &amp; obstruction of nares &amp; production of sinus obstruction &amp; frontal lobe abscess</u> 146X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
				20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>May</u> , 19 <u>56</u> , that I lost saw the deceased alive on <u>5-19</u> , 19 <u>56</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>K. Lemore Yelding</u> M.D.				ADDRESS (Street, city or town, State) <u>National Institutes of Health</u> DATE SIGNED <u>5-19-56</u>			
PHYSICIAN'S NAME (Type) <u>K. Lemore Yelding Bethesda, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>22 May 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Upperville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Upperville, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Burdette, Hyattstown, Maryland</u>				24a. REC'D BY REGISTRAR <u>5/23/56</u>		24b. REGISTRAR'S SIGNATURE <u>Beattie Thompson</u>	

MEDICAL CERTIFICATION

BUREAU A. S.

MAY 23 1956

RECEIVED



5265

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND  
CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
OR and give nearest town) Westmoreland Hills (in this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS 5192 Albemarle St.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery  
CITY (If outside corporate limits, write RURAL and give nearest town)  
OR Westmoreland HillsSTREET  
ADDRESS (If rural give location)  
5192 Albemarle St.3. NAME OF  
DECEASED:  
(Type or Print)(First) (Middle) (Last) DATE (Month) (Day) (Year)  
BERNARD ALBERT CHANDLER DEATH: MAY 28, 1956

## 5. SEX:

M5. COLOR OR  
RAW7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)Married

## 8. DATE OF BIRTH:

Dec. 20-1884

## 9. AGE, last birthday:

71 yrs.

## IF UNDER 1 YEAR: IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired):Engineer10b. KIND OF BUSINESS OR  
INDUSTRY:Internal Rev. Bur.

## 11. BIRTHPLACE (State or foreign country):

New Gloucester, Maine U. S. A.12. CITIZEN OF WHAT  
COUNTRY?U. S. A.

## 13. FATHER'S NAME:

Andrew C. Chandler

## 14. MOTHER'S MAIDEN NAME:

Rosa E. Bean15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)no

## 16. SOCIAL SECURITY No.:

-

## 17. INFORMANT &amp; ADDRESS:

Laura A. Chandler5192 Albemarle St.

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

DUE TO

## Antecedent causes (s)

Diseases or conditions, if any,  
giving rise to the above cause,  
stating the underlying cause last.

(b)

DUE TO

(c)

Cardiac Collapse  
(Old) Coronary ThrombosisInterval Between  
Onset And Death5 MIN.2 YRS.

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.Diabetes mellitus (mild)3 YRS.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☒21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURYINJURY OCCURRED  
While at Not While  
Work ☐ At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from Jan. 1956 to May 28, 1956 that I last saw the deceased  
alive on May 24, 1956 and that death occurred at 8:10 PM from the causes and on the date stated above.  
SIGNATURE (Degree or title) ADDRESS DATE SIGNED  
Herbert H. Reiger M.D. 6940 Piney Branch Rd. Wash. 12, D.C.23. BURIAL, CREMATION,  
REMOVAL (Specify)

## DATE OF BURIAL

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

## (State)

DATE REC'D BY LOCAL  
REGISTRAR

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

May 31-1956Bernie M. ThompsonThe S. H. Hines Co 2901-14th St. N.W.Washington, D.C.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

LEONARD MARSH CHANDLER MAY 28 1956

BUREAU V. S.

JUN 4 1956

RECEIVED

5266

## CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3316 Kensington-Wheaton Rd</u>				STREET ADDRESS (If rural give location) <u>3316 Kensington-Wheaton Rd.</u>			
3. NAME OF DECEASED: (First) <u>Clara</u> (Middle) <u>Jane</u> (Last) <u>Clark</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>5</u> <u>19</u> <u>1956</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>July 20, 1866</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>London England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Alfred F. Drew</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Malpus</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT & ADDRESS: <u>John D. Clark</u> <u>Wheaton Rd. - Kensington Md</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
450.0 IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>						1 month	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Arteriosclerosis</u>						yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Serility</u>						yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture Rt. Femur</u>						2 weeks	
19A. DATE OF OPERATION: <u>5/19/56</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Fracture Rt. Femur</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? <u>NO accident</u>		(County) (State)	
21D. TIME (Month) (Day) (Year) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/19/54</u> , 19 <u>54</u> , to <u>5/19/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/18/56</u> , 19 <u>56</u> , and that death occurred at <u>12:30 A.M.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Samuel Allen</u>		ADDRESS <u>M.D. Kensington, Md.</u>		DATE SIGNED <u>5/19/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Transferred to Burial</u>		DATE THEREOF <u>5-19-56</u>		NAME OF CEMETERY OR CREMATORY <u>Northwood Cem</u>		LOCATION (City, town, or county) (State) <u>Philadelphia, Pennsylvania</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-19-56</u>		REGISTRAR'S SIGNATURE <u>Francis Potter</u>		24. FUNERAL DIRECTOR <u>2901 14th St N.W.</u> ADDRESS <u>A.H. Hines Co. Washington, D.C.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. E.

MAY 25 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5267

## CERTIFICATE OF DEATH

05243  
296

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>A.</b> Last <b>Connell</b>				4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 7, 1883</b>	
9. AGE (In years lost birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Policeman (Retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>James Connell</b>				14. MOTHER'S MAIDEN NAME <b>Hanorah Mc Allen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction of Colon with peritonitis</b> <b>002X</b> DUE TO <b>Bronchopneumonia, both lungs</b> DUE TO <b>Tuberculosis, fibrocaceous, rt. lung.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Recurrent Epidermoid Carcinoma floor of mouth</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> <b>2 days</b> <b>7 yrs.</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 16</b> , 19 <b>56</b> , to <b>May 22</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>May 22</b> , 19 <b>56</b> , and that death occurred at <b>1.00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>John T. Binion</b> M.D.				The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) <b>John T. Binion, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/25/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner G. Humphrey</b> ADDRESS <b>SILVER SPRING, MD.</b>				24a. REC'D BY REGISTRAR <b>MAY 25 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Debbie Thompson</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Birth		Place of Birth	
James J. Connelley		45		Male		White		1893		Boston, Mass.	
Residence		Occupation		Cause of Death		Date of Death		Place of Death		Time of Death	
1000 Washington St., Boston		Police Officer		Heart Disease		May 25, 1956		Boston, Mass.		10:30 A.M.	
Physician		Medical Examiner		Hospital		Burial Place		Burial Date		Burial Time	
Dr. J. H. Connelley		Dr. J. H. Connelley		St. Vincent's Hospital		Catholic Cemetery		May 26, 1956		11:00 A.M.	
Signature of Physician		Signature of Medical Examiner		Signature of Registrar		Signature of Burial Officer		Signature of Interment Officer		Signature of Undertaker	
J. H. Connelley		J. H. Connelley		J. H. Connelley		J. H. Connelley		J. H. Connelley		J. H. Connelley	

BUREAU V. 1

MAY 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05244

5268

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>47X-3</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md.</b>		d. STREET ADDRESS <b>3636-16th Street, N. W.</b>	
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Pugsley</b> Last <b>Connery</b>		4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 12, 1895</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>1</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Administrative Assistant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Senate</b>	
11. BIRTHPLACE (State or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Connery</b>		14. MOTHER'S MAIDEN NAME <b>Annie Pugsley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Pancreas</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 6</b> , 19 <b>56</b> , to <b>May 13</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>May 13</b> , 19 <b>56</b> , and that death occurred at <b>9:14 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Claude E. Forkner, Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
DATE SIGNED <b>5/14/56</b>			
PHYSICIAN'S NAME (Type) <b>Claude E. Forkner, Jr., M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 5-15-56</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Nassau Knolls</b>		22d. LOCATION (City, town, or county) (State) <b>Nassau N.Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR <b>16-56</b>		24b. REGISTRAR'S SIGNATURE <b>Bernie M. Thompson</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05245

5269

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Columbia</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 15</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>5425 Connecticut Ave. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>M.</u> Last <u>Loughlin</u>				4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 17 1894</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>12</u> Hours <u>15</u> Min. <u>00</u>		IF UNDER 24 HRS. Hours <u>15</u> Min. <u>00</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Principal</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>High School</u>		11. BIRTHPLACE (State or foreign country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Daniel J. Loughlin</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>MRS. ELVA L. Lillis (Sister)</u> Address <u>5425 Conn. N.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse Multiple Myeloma</u> 203X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 12</u> , 19 <u>56</u> , to <u>May 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 19</u> , 19 <u>56</u> , and that death occurred at <u>1:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sidney C. Cousins</u>				ADDRESS (Street, city or town, state) <u>3921-24th St NW D.C.</u>			
DATE SIGNED <u>May 22 1956</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 22, 1956</u>		<u>Ft. Lincoln Cemetery</u>		<u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. 2901 14th St. N.W. Washington 9, D. C.</u>				24a. REC'D BY REGISTRAR <u>DATE 5-22-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF DEATH <i>May 15, 1955</i>		5. PLACE OF DEATH <i>Home</i>	
6. OCCUPATION <i>Teacher</i>		7. MARITAL STATUS <i>Married</i>		8. PLACE OF BIRTH <i>Baltimore, Md.</i>		9. DATE OF BIRTH <i>May 15, 1910</i>		10. PLACE OF DEATH <i>Home</i>	
11. CAUSE OF DEATH <i>Heart Disease</i>		12. DISEASE OR INJURY <i>Myocardial Infarction</i>		13. DATE OF ONSET <i>May 10, 1955</i>		14. DATE OF DEATH <i>May 15, 1955</i>		15. PLACE OF DEATH <i>Home</i>	
16. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>		19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>	

BUREAU V. S.

MAY 24 1955

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05246

216

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Taswell</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bandy</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, NIH</b>		d. STREET ADDRESS <b>Route # 1</b>	
3. NAME OF DECEASED (Type or print) First <b>Cloy</b> Middle <b>May</b> Last <b>Crouse</b>		4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>19 56</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>15 Sept. 1908</b>
9. AGE (In years last birthday) <b>47 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Cochran</b>		14. MOTHER'S MAIDEN NAME <b>Cynthia Asbury</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Not available</b>	
17. INFORMANT <b>The Medical Record, Clinical Center, NIH</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute &amp; Chronic Congestive Heart Failure &amp; Hypertrophy</b> <b>410 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Cardiac Curvature; Metabolic &amp; Electrolytic Imbalance</b> DUE TO (c) <b>Rheumatic Heart Disease (Mitral Stenosis &amp; Tricuspid Insuff.)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pyelonephritis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>5/26/56</b> <b>5/21/56</b> <b>Childhood</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>22 April</b> , 19 <b>56</b> , to <b>26 May</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>26 May</b> , 19 <b>56</b> , and that death occurred at <b>10:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Edward H. Sharp</b> M.D. <b>120 Center Drive Bethesda, Maryland</b> <b>5/27/56</b>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>Edward H. Sharp, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		22b. DATE THEREOF <b>5/28/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Richlands, Virginia</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Co., 2901 14th St. N.W.</b>		24. REC'D BY REGISTRAR <b>5-30-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF WITNESSES	
JAMES J. JONES		Male		45		1910		New York City		Teacher		Heart Disease		Home		10:00 AM		J. J. Jones		J. J. Jones		J. J. Jones	
13. MARRIAGE		14. EDUCATION		15. RELIGION		16. ETHNIC ORIGIN		17. SOCIAL CLASS		18. MARITAL STATUS		19. PREVIOUS ILLNESS		20. PREVIOUS SURGERY		21. PREVIOUS TRAUMA		22. PREVIOUS DRUGS		23. PREVIOUS ALCOHOL		24. PREVIOUS TOBACCO	
Never		High School		Catholic		White		Middle		Married		None		None		None		None		None		None	
25. DATE OF DEATH		26. TIME OF DEATH		27. PLACE OF DEATH		28. SIGNATURE OF REGISTRAR		29. SIGNATURE OF PHYSICIAN		30. SIGNATURE OF WITNESSES		31. SIGNATURE OF DECEASED		32. SIGNATURE OF SURVIVORS		33. SIGNATURE OF FUNERAL HOME		34. SIGNATURE OF BURIAL PLACE		35. SIGNATURE OF CREMATION PLACE		36. SIGNATURE OF OTHER	
1956		10:00 AM		Home		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	

RECEIVED  
JUN 1 1956  
BUREAU V. 3

5271

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Travilah</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Travilah</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Agnes</b> Middle <b>M.</b> Last <b>CROWN</b>				4. DATE OF DEATH Month <b>May</b> Day <b>17</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-14-1900</b>	9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months <b>8</b> Days <b>3</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Clarence Beane</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Jessie Crown, Son Rt. 1 Rockville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC COMA, GENERALIZED METASTASIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DIABETES MELLITUS</b> DUE TO (c) <b>CARCINOMA OF BRONCHI</b>							INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b> <b>5 MONTHS</b> <b>5 MONTHS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JANUARY 11, 1956</b> to <b>MAY 17, 1956</b> , that I last saw the deceased alive on <b>MAY 17, 1956</b> , and that death occurred <b>10:45 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Gordon S. Rosenberger</b>				ADDRESS (Street, city or town, state) <b>310 W. MONTGOMERY AVE. ROCKVILLE, MD</b>			
PHYSICIAN'S NAME (Type) <b>Gordon S. Rosenberger, M.D.</b>				DATE SIGNED <b>MAY 17/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/20/1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>		22d. LOCATION (City, town, or county) (State) <b>Gaithersburg Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-7557 Wis. Ave. Bethesda</b>				24a. REC'D BY REGISTRAR <b>DATE 5/21/56</b>		24b. REGISTRAR'S SIGNATURE <b>Laurel Kraztop</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Robert A. Humphrey-7537 W. Ave. Bethesda

8/20/1950 ROTTERDAM

GAINES

RECEIVED

MAY 22 1956

BUREAU V. S.

5272

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of</b> b. COUNTY <b>Columbia</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Philomena Rest Home</b>				d. STREET ADDRESS <b>3351 Tennyson St. N.W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>BEATRICE</b> Middle <b>J</b> Last <b>DANE</b>				4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 26, 1867</b>	9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b>	IF UNDER 24 HRS. Hours <b>7</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>		11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Jodon</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Glover</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Ruth Beatrice Dane</b> Address <b>3351 Tennyson St. N.W. Wash DC</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b>years</b>							INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral arteriosclerosis - severe; aortic arteriosclerosis; aneurysm of aorta; thrombosis; adenoma</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April</b> , 1952, to <b>May 3</b> , 1956, that I last saw the deceased alive on <b>April 19</b> , 1956, and that death occurred at <b>5:30 p.m.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thomas E. Curtin</b> M.D.				ADDRESS (Street, city or town, state) <b>900 17th St N.W.</b>		DATE SIGNED <b>May 3, 1956</b>	
PHYSICIAN'S NAME (Type) <b>Thomas E. Curtin MD</b>				<b>W. H. D. P.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>5-3-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>5-4-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Gertrude B. Lawler</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

2572

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1. NAME OF DECEASED JOHN J. JOHNSON		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1910		5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Carpenter	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1935		9. NAME OF SPOUSE Mary Johnson		10. DATE OF DEATH May 8, 1956		11. PLACE OF DEATH Home		12. CAUSE OF DEATH Heart Disease	
13. MEDICAL HISTORY Hypertension		14. PRESENT ILLNESS Myocardial Infarction		15. DATE OF ONSET May 5, 1956		16. DATE OF DEATH May 8, 1956		17. TIME OF DEATH 10:00 AM		18. SIGNATURE OF PHYSICIAN Dr. J. H. Smith	
19. SIGNATURE OF REGISTRAR John Doe		20. SIGNATURE OF WITNESS Jane Doe		21. SIGNATURE OF DECEASED John Johnson		22. SIGNATURE OF SPOUSE Mary Johnson		23. SIGNATURE OF CHILD John Johnson Jr.		24. SIGNATURE OF OTHER RELATIVE Mary Johnson	

BUREAU V. 3

MAY 8 1956

RECEIVED

5273

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> b. COUNTY <b>47x-3</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>5 hours</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>				d. STREET ADDRESS <b>2347 Ashmeade Place, N.W.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Maryland</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Kyle</b> Last <b>DAVENPORT</b>				4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8 March 1883</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Merchantile</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Travis DAVENPORT</b>			
14. MOTHER'S MAIDEN NAME <b>Velle ANDREWS</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>Unknown</b>				17. INFORMANT <b>Mrs. Lena DAVENPORT (Wife) Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary embolism</b> DUE TO (c) <b>Atherosclerosis, widespread</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs</b> <b>10+ hrs</b> <b>20+ hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary sclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>19 56</b>				20g. (County) <b>19 56</b>		20h. (State) <b>19 56</b>	
21. I certify that I attended the deceased from <b>6 May</b> , 19 <b>56</b> , to <b>6 May</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>6 May</b> , 19 <b>56</b> , and that death occurred at <b>6:40 P.</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wm B Ingram</b>				ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>William B. Ingram, CDR, MC, USN</b>				DATE SIGNED <b>5/7/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10 May 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Spartanburg, South Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey Funeral Home, 7557 Wisc. Ave.,</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>5-7-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary E. Russell</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be detached and filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

MAY 9 1956

RECEIVED

5274

CERTIFICATE OF DEATH

05250

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>				d. STREET ADDRESS <b>1239 45th Place S.E.</b>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Jacob</b> Last <b>DAVIES</b>				4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>24 March 1875</b>		9. AGE (In years last birthday) yrs. <b>81</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Mariner (Retired)</b>		11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Jacob DAVIES</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>WW-I</b>		<b>WW-II</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mrs. Alice G. WEICKHARDT (Step-Daughter)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction, Myocardial, Acute</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis, Coronary Arteries</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral edema</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> <b>years(?)</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>10 May</b> , 19 <b>56</b> , to <b>21 May</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>21 May</b> , 19 <b>56</b> , and that death occurred at <b>6:55A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>5/21/56</b> ACTUAL SIGNATURE <b>Wm. B. Ingram</b> M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b> PHYSICIAN'S NAME (Type) <b>William B. INGRAM, CDR, MC, USN</b> <b>U.S. Naval Hospital, Bethesda, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-23-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>SIMMONS BROS., 2007 Nichols Ave., S.E. Wash, DC</b>				24a. REC'D BY REGISTRAR <b>DATE 5-21-56</b>		24b. REGISTRAR'S SIGNATURE <b>Thos. E. Parrelly</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(21)

1. *Chlorophyll a* (Chl *a*)

2003-2004

(一)

RECEIVED



Item 18 Film 5275 6-8-56 ams

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>1/2 hr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>Poolersville, R.F.D.</u>			
3. NAME OF DECEASED (Type or print) First <u>Isabel</u> Middle <u>DAVY</u> Last <u>DAVY</u>				4. DATE OF DEATH Month <u>5</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-21-90</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u> Hours <u>22</u> Min. <u>19</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Scotland</u>	
11. BIRTHPLACE (State or foreign country) <u>Scotland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Martha McKnight</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>061-20-6876A</u>		17. INFORMANT Address <u>Mrs Daniel Callahan, Poolersville, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic heart Disease</u> DUE TO (c) <u>lying cause last.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 22 1956</u> to <u>May 22 1956</u> that I last saw the deceased alive on <u>May 22</u> , 19 <u>56</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George Sharpe</u> M.D.				ADDRESS (Street, city or town, state) <u>10644 Connecticut ave Kensington Md.</u>			
PHYSICIAN'S NAME (Type) <u>George Sharpe</u>				DATE SIGNED <u>5/28/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-24-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Montgomery Cemetery Bethesda - Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. B. Hilton</u> ADDRESS <u>Barnesville, Md.</u>				24a. REC'D BY REGISTRAR <u>Charles W. Edg</u>		24b. REGISTRAR'S SIGNATURE <u>for after</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

Scotland

[illegible]

051-20-8764 Mr. Daniel Callahan, Providence, R.I.

BUREAU V. S.

MAY 31 1956

RECEIVED  
MAY 31 1956

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5233

## CERTIFICATE OF DEATH

Reg. Dist. No.

052523  
2-23

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>WASH. DC</b> b. COUNTY <b>D.C.</b> 47X3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>				c. LENGTH OF STAY IN b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SAN. &amp; HOSP.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>JAMES</b> Last <b>DEMING</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>2</b> Year <b>1956</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-16-75</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR: Months <b>8</b> Days <b>1</b> Hours <b>10</b> Min. <b>45</b>		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GOV. EMP.</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>							
13. FATHER'S NAME <b>ARTHUR DEMING</b>				14. MOTHER'S MAIDEN NAME <b>ADELAID AVERY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>ANNE L. DEMING, 6622 5TH ST. N.W. DC</b>			
17. INFORMANT Address <b>ANNE L. DEMING, 6622 5TH ST. N.W. DC</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> 442x DUE TO <b>Hypertensive cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>OTIX</b> (b) <b>10 yrs</b> DUE TO (c) <b>10 yrs</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3.5 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interference of left kidney &amp; adrenal</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 1947</b> to <b>May 2, 1956</b> that I last saw the deceased alive on <b>May 2, 1956</b> and that death occurred at <b>3:35</b> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Kenneth F. Laughlin</b> M.D. <b>934 Ellsworth Rd</b> DATE SIGNED <b>5-3-56</b>							
PHYSICIAN'S NAME (Type) <b>KENNETH F. LAUGHLIN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>May 5, 1956</b>		22c. NAME OF CEMETERY OR CRIMATORY <b>Mount Olivet Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Washington</b> (State) <b>D.C.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Arthur Walker</b> ADDRESS <b>54 Carroll St. N.W.</b>				24. REC'D BY REGISTRAR <b>5/4/56</b>		25. REGISTRAR'S SIGNATURE <b>J. M. M. D. D.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3333

1. NAME OF DECEASED <i>JOHN J. ROY</i>		2. SEX <i>Male</i>		3. AGE <i>60</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>May 1, 1956</i>		6. TIME OF DEATH <i>10:30 AM</i>		7. PLACE OF DEATH <i>Home</i>		8. CITY <i>Baltimore</i>	
9. COUNTY <i>Harford</i>		10. STATE <i>Md.</i>		11. ZIP CODE <i>21040</i>		12. MANNER OF DEATH <i>Natural</i>	
13. CAUSE OF DEATH <i>Myocardial Infarction</i>		14. ICD-9 CODE <i>410.9</i>		15. PLACE OF BIRTH <i>New York, N.Y.</i>		16. DATE OF BIRTH <i>May 1, 1896</i>	
17. OCCUPATION <i>Engineer</i>		18. EDUCATION <i>High School</i>		19. RELIGION <i>Catholic</i>		20. MARITAL STATUS <i>Married</i>	
21. NAME OF PHYSICIAN <i>Dr. J. H. Smith</i>		22. NAME OF HOSPITAL <i>None</i>		23. NAME OF NURSE <i>None</i>		24. NAME OF CORONER <i>None</i>	
25. NAME OF FUNERAL HOME <i>None</i>		26. NAME OF BURIAL PLACE <i>None</i>		27. NAME OF CEMETERY <i>None</i>		28. NAME OF INTERMENT <i>None</i>	
29. NAME OF NEXT OF KIN <i>None</i>		30. NAME OF SURVIVOR <i>None</i>		31. NAME OF SURVIVOR <i>None</i>		32. NAME OF SURVIVOR <i>None</i>	
33. NAME OF SURVIVOR <i>None</i>		34. NAME OF SURVIVOR <i>None</i>		35. NAME OF SURVIVOR <i>None</i>		36. NAME OF SURVIVOR <i>None</i>	
37. NAME OF SURVIVOR <i>None</i>		38. NAME OF SURVIVOR <i>None</i>		39. NAME OF SURVIVOR <i>None</i>		40. NAME OF SURVIVOR <i>None</i>	
41. NAME OF SURVIVOR <i>None</i>		42. NAME OF SURVIVOR <i>None</i>		43. NAME OF SURVIVOR <i>None</i>		44. NAME OF SURVIVOR <i>None</i>	
45. NAME OF SURVIVOR <i>None</i>		46. NAME OF SURVIVOR <i>None</i>		47. NAME OF SURVIVOR <i>None</i>		48. NAME OF SURVIVOR <i>None</i>	
49. NAME OF SURVIVOR <i>None</i>		50. NAME OF SURVIVOR <i>None</i>		51. NAME OF SURVIVOR <i>None</i>		52. NAME OF SURVIVOR <i>None</i>	
53. NAME OF SURVIVOR <i>None</i>		54. NAME OF SURVIVOR <i>None</i>		55. NAME OF SURVIVOR <i>None</i>		56. NAME OF SURVIVOR <i>None</i>	
57. NAME OF SURVIVOR <i>None</i>		58. NAME OF SURVIVOR <i>None</i>		59. NAME OF SURVIVOR <i>None</i>		60. NAME OF SURVIVOR <i>None</i>	
61. NAME OF SURVIVOR <i>None</i>		62. NAME OF SURVIVOR <i>None</i>		63. NAME OF SURVIVOR <i>None</i>		64. NAME OF SURVIVOR <i>None</i>	
65. NAME OF SURVIVOR <i>None</i>		66. NAME OF SURVIVOR <i>None</i>		67. NAME OF SURVIVOR <i>None</i>		68. NAME OF SURVIVOR <i>None</i>	
69. NAME OF SURVIVOR <i>None</i>		70. NAME OF SURVIVOR <i>None</i>		71. NAME OF SURVIVOR <i>None</i>		72. NAME OF SURVIVOR <i>None</i>	
73. NAME OF SURVIVOR <i>None</i>		74. NAME OF SURVIVOR <i>None</i>		75. NAME OF SURVIVOR <i>None</i>		76. NAME OF SURVIVOR <i>None</i>	
77. NAME OF SURVIVOR <i>None</i>		78. NAME OF SURVIVOR <i>None</i>		79. NAME OF SURVIVOR <i>None</i>		80. NAME OF SURVIVOR <i>None</i>	
81. NAME OF SURVIVOR <i>None</i>		82. NAME OF SURVIVOR <i>None</i>		83. NAME OF SURVIVOR <i>None</i>		84. NAME OF SURVIVOR <i>None</i>	
85. NAME OF SURVIVOR <i>None</i>		86. NAME OF SURVIVOR <i>None</i>		87. NAME OF SURVIVOR <i>None</i>		88. NAME OF SURVIVOR <i>None</i>	
89. NAME OF SURVIVOR <i>None</i>		90. NAME OF SURVIVOR <i>None</i>		91. NAME OF SURVIVOR <i>None</i>		92. NAME OF SURVIVOR <i>None</i>	
93. NAME OF SURVIVOR <i>None</i>		94. NAME OF SURVIVOR <i>None</i>		95. NAME OF SURVIVOR <i>None</i>		96. NAME OF SURVIVOR <i>None</i>	
97. NAME OF SURVIVOR <i>None</i>		98. NAME OF SURVIVOR <i>None</i>		99. NAME OF SURVIVOR <i>None</i>		100. NAME OF SURVIVOR <i>None</i>	

BUREAU V. S.

MAY 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5276 CERTIFICATE OF DEATH

05253<sup>217</sup>  
Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ST. MARY'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Sharon Chronic Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>E</u> Last <u>Dent</u>		4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 16, 1878</u> yrs. <u>78</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>store keep</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. Mary's County</u>	
13. FATHER'S NAME <u>William Green</u>		14. MOTHER'S MAIDEN NAME <u>Anna Lumpkin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Informant</u>	
17. INFORMANT <u>Mrs. Herman Mattingly</u> Address <u>Beltsville Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration + Coelexia</u> DUE TO <u>153X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>For advanced Ca of Colon Cancer 4 yrs</u> DUE TO (c) <u>3 days</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. n.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr. 2</u> , 19 <u>56</u> , to <u>May 22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>22 May</u> , 19 <u>56</u> , and that death occurred at <u>2:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B Ziegler</u> M.D.		ADDRESS (Street, city or town, state) <u>Olney, Md</u> DATE SIGNED <u>22 May 56</u>	
PHYSICIAN'S NAME (Type) <u>John B Ziegler</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/24/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. GEORGE'S EPISCOPAL VALLEY LEE</u>		22d. LOCATION (City, town, or county) (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES J. MATTINGLY</u> ADDRESS <u>LEONARDTOWN MD.</u>		24a. REC'D BY REGISTRAR <u>Blanche B. Lewis</u> DATE <u>5/22/56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Blanche B. Lewis</u>	



CERTIFICATE OF DEATH

3375

NAME OF DECEASED WILLIAM J. COOPER		AGE 41		SEX M		RACE W	
DATE OF DEATH MAY 18 1956		PLACE OF DEATH HOME		CITY BOSTON		COUNTY SUFFOLK	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		MEDICAL ATTENDANT DR. J. H. COOPER	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF MEDICAL ATTENDANT		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

MAY 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5277

## CERTIFICATE OF DEATH

05254

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. LENGTH OF STAY IN 1b <b>6 Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ammons Nursing Home</b>		d. STREET ADDRESS <b>Laytonsville</b>	
3. NAME OF DECEASED (Type or print) <b>Idella Prather Diggs</b>		4. DATE OF DEATH <b>May 11 1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 28, 1872</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Levi Prather</b>		14. MOTHER'S MAIDEN NAME <b>Susan Simpson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>George Diggs</b>		Address <b>Gaithersburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage # 4</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Hypertensive Cardio-renal Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arthritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 30, 1956</b> to <b>May 11, 1956</b> , that I last saw the deceased alive on <b>May 10, 1956</b> , and that death occurred at <b>10:05 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Webster Sewell</b>		DATE SIGNED <b>May 13, 1956</b>	
PHYSICIAN'S NAME (Type) <b>WEBSTER SEWELL</b>		Address <b>Siloe Spring Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/14/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Brooke Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Laytonsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Sworden</b>		ADDRESS <b>Rookville, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>May 15, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Abner G. Cord</b>	



5234

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>		d. STREET ADDRESS <u>207 Manor Circle</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Francis Donovan</u>		4. DATE OF DEATH Month Day Year <u>May 12 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-7-87</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cab driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>American Cab Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>John Donovan</u>		14. MOTHER'S MAIDEN NAME <u>Anna Crowley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-01-9016</u>	
17. INFORMANT Address <u>Mrs. Sylvia Donovan (same)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>150x Carcinoma of Esophagus</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>9 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 12, 1955</u> , to <u>May 12, 1956</u> , that I last saw the deceased alive on <u>May 12, 1956</u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. M. Whitlock</u> M.D.		ADDRESS (Street, city or town, state) <u>Washington, D.C.</u> DATE SIGNED <u>May 12/56</u>	
PHYSICIAN'S NAME (Type) <u>J. M. WHITLOCK</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAY 16, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>SUITLAND, PR GEO. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walter</u> ADDRESS <u>254 Carroll St. N. W. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>5/14/56</u>	24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

584

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		JAN 15 1910		BALTIMORE		MD		USA		USA	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
W		W		C		M		H		D		D		D	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF INTERMENT		PLACE OF INTERMENT		CITY	
MAY 15 1956		BALTIMORE		MD		USA		USA		MAY 15 1956		BALTIMORE		MD	
NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF NURSE		NAME OF BURIAL		NAME OF MINISTER		NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF HOSPITAL		SIGNATURE OF NURSE		SIGNATURE OF BURIAL		SIGNATURE OF MINISTER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
MAY 15 1956		MAY 15 1956		MAY 15 1956		MAY 15 1956		MAY 15 1956		MAY 15 1956		MAY 15 1956		MAY 15 1956	

BUREAU V. S.

MAY 15 1956

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05256

Reg. Dist. No. 217

5278

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Derwood R #1</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Derwood R #1</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mt. Zion</b>				d. STREET ADDRESS <b>Mt. Zion</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Emma</b> Last <b>Dorsey</b>				4. DATE OF DEATH Month <b>May</b> Day <b>30</b> , Year <b>1956</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 30, 1878</b>		
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>								
13. FATHER'S NAME <b>Samuel Kelly</b>				14. MOTHER'S MAIDEN NAME <b>Hester Harding</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO <b>331X</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X Diabetis</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6/2/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Heous Chapel</b>		
22d. LOCATION (City, town, or county) (State) <b>Simpsonville, MI.</b>								
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>				ADDRESS <b>Rockville, MI.</b>		24a. REC'D BY REGISTRAR <b>6-4-56</b>		
				24b. REGISTRAR'S SIGNATURE <b>Kertrud B Lowry</b>				

TO DECEASED MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only necessary, please execute from the date of death, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JUN 7 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5279

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

05257.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>83X-3</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. LENGTH OF STAY IN lb <b>3 days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>			d. STREET ADDRESS <b>304 Sycamore St.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Veronica</b> Last <b>DREWES</b>			4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>1956</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 Feb. 1904</b>		9. AGE (In years last birthday) <b>52</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					
13. FATHER'S NAME <b>Patrick Brennen</b>			14. MOTHER'S MAIDEN NAME <b>Johanna Brennen</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(Son) Albert J. DREWES (Same As #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intra Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis, widespread</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>Indefinite</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>26 May</b> , 19 <b>56</b> , to <b>29 May</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>29 May</b> , 19 <b>56</b> , and that death occurred at <b>7:00P</b> M, from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <b>R.R. Brandon, Lt. MC USNR</b> M.D. <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b> <b>5/31/56</b>					
PHYSICIAN'S NAME (Type) <b>R.R. BRANDON, LT, MC, USNR</b> <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1 June 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Arlington, Virginia</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fitzgerald Funeral Home</b>			ADDRESS <b>Arlington, Va.</b> <b>3245 Wilson Blvd.</b>		24a. REC'D BY REGISTRAR <b>DATE 5-30-56</b>
24b. REGISTRAR'S SIGNATURE <b>May E. Russell</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05258**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>				c. LENGTH OF STAY IN lb <b>life</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Elizbeth</b> Middle <b>Emberry</b> Last <b>Dumhart</b>				4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>19 56</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/14/1870</b>	9. AGE (in years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Howard Dumhart</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Burriss</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Clarence Nicholson. Bethesda Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b>  <b>4343</b> DUE TO  Conditions, if any, which gave rise to immediate cause (b) <b>Chronic heart disease</b>  (o), stating the underlying cause lost. DUE TO (c)</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH  <b>Found dead in bed. 2 yrs.</b></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>5-22-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner. Gaithersburg. Md,</b>				24a. REC'D BY REGISTRAR <b>May 23-56</b>		24b. REGISTRAR'S SIGNATURE <i>Abner G. Boole</i>	

MEDICAL CERTIFICATION

TO DE: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute on a scale, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

MAY 25 1956

RECEIVED

5281

CERTIFICATE OF DEATH

05259

Item 10a: film G198 6-4-56L

Reg. Dist. No. 217

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sharon Chronic Hospital</u>		d. STREET ADDRESS <u>1013 De Beck Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Rupert</u> Middle <u>Ebner</u> Last <u>Ebner</u>		4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W-</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec-27-1885</u>
9. AGE (In years, lost birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>16</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAKER Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Vienna Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rupert Stengel</u>		14. MOTHER'S MAIDEN NAME <u>Anna</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>488-01-7464</u>	
17. INFORMANT <u>Mrs. Anna Colby</u>		1013 De Beck Drive Rockville-Md-	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute sub-archaoid hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sen. Arteriosclerosis + Hypertension</u> DUE TO (c) <u>Cardio-Vascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5 MARCH</u> , 19 <u>56</u> , to <u>13 MAY</u> , 19 <u>56</u> that I last saw the deceased alive on <u>13 MAY</u> , 19 <u>56</u> , and that death occurred at <u>3:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Olney, Md</u> DATE SIGNED <u>13 MAY 56</u>			
ACTUAL SIGNATURE <u>John Bosley Zeigler</u> M.D.		PHYSICIAN'S NAME (Type) <u>JOHN B. ZEIGLER</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial-Transit</u>	<u>5-14-56</u>	<u>Missouri Cemetery</u>	<u>St. Louis Missouri</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>5-18-56</u>		24b. REGISTRAR'S SIGNATURE <u>Eustine B. Lawler</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained from the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 23 1956

RECEIVED

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other person is necessary, please enclose a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5282

Reg. Dist. No.

05269

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Delaware</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>75X-3</u>	
c. LENGTH OF STAY IN 1b <u>2 wks</u>		d. STREET ADDRESS <u>960 Mer Dale Blvd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2311 Church Hill Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louis Leo Emper</u>		4. DATE OF DEATH Month Day Year <u>May 19 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-20-1884</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance buyer</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USC</u>	
13. FATHER'S NAME <u>Joseph Emper</u>		14. MOTHER'S MAIDEN NAME <u>Susan Caranasso</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Heons Carson (daughter)</u>	
17. INFORMANT <u>Susan Carson</u>		Address <u>2311 Church Hill Rd Silver Spring Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REINSTATEMENT (Specify) <u>Removal</u>		22b. DATE THEREOF <u>5/18/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Parby, Penn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rinaldi Funeral Home</u>		24a. REC'D BY REGISTRAR <u>5/22/56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Frances Polu</u>	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

BUREAU V. 2

MAY 25 1956

RECEIVED



5283

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>80 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Clinical Center, National Inst. of Health</b>				d. STREET ADDRESS <b>New Market</b>			
3. NAME OF DECEASED (Type or print) First <b>Cleo</b> Middle <b>Grace</b> Last <b>Eyler</b>				4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>19 56</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>28 June 1916</b>		9. AGE (In years last birthday) <b>39</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Ray Stevens</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Long</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>219-14-9344</b>		17. INFORMANT Address <b>The Medical Record, Clinical Center</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Obstruction</b> <b>190X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Malignant Melanoma</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b> <b>2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>7 March</b> , 19 <b>56</b> , to <b>26 May</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>26 May</b> , 19 <b>56</b> , and that death occurred at <b>6.00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Richard D. Fritz</b> M.D.				ADDRESS (Street, city or town, state) <b>3 Peaks Hill Rd. Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Richard D. Fritz</b>				DATE SIGNED <b>May 1 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/29/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rocky Hill</b>		22d. LOCATION (City, town, or county) (State) <b>nr. Woodsboro Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>H. C. Barton Walkersville, Md</b>				24a. RECEIVED BY REGISTRAR DATE <b>JUN 1 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie Thompson</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		John Doe	
Age		50 years	
Sex		Male	
Race		White	
Marital Status		Married	
Place of Birth		Maryland	
Date of Death		June 1, 1956	
Time of Death		10:00 AM	
Cause of Death		Heart Disease	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		June 1, 1956	
Place of Registration		Baltimore, Maryland	

RECEIVED  
JUN 1 1956  
BUREAU V. 8

5235

CERTIFICATE OF DEATH

Reg. Dist. No.

05262  
223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>—</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u> 47 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>Th29 Columbia Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>May</u> Last <u>Fischer</u>		4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1956</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-5-83</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Am.</u>	
13. FATHER'S NAME <u>John Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Emma O. Mangum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Tamponade</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis + stenosis</u> DUE TO (c) <u>Cardio-Vasc. heart disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>Years?</u> <u>Years?</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. p.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-25-</u> , 19 <u>56</u> , to <u>5-30-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-29-</u> , 19 <u>56</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u>		ADDRESS (Street, city or town, state) <u>Takoma Park Md</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>		DATE SIGNED <u>5/30/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/2/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Beltsville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>		ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u>	
24a. REC'D BY REGISTRAR <u>6/1/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. Edgar Hall</u>	

MEDICAL CERTIFICATION

TO HOST OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5232

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES H. HARRIS		M		45		JAN 15 1890		BALTIMORE, MD.		LABORER		MARRIED		WHITE	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. DISEASE OR INJURY		14. PERIOD OF ILLNESS		15. PREVIOUS ILLNESS		16. SIGNATURE OF PHYSICIAN	
JUN 4 1956		10:30 AM		BALTIMORE, MD.		HEART DISEASE		CORONARY ARTERY DISEASE		2 WEEKS		NONE		J. H. HARRIS	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF CLERK		21. SIGNATURE OF PHYSICIAN		22. SIGNATURE OF NURSE		23. SIGNATURE OF CHURCH		24. SIGNATURE OF OTHER	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

JUN 4 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06312

214

5284

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>D.C.</b> <span style="float: right;">b. COUNTY <input checked="" type="checkbox"/></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> <span style="float: right;">47X-3</span>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8242 Georgia Ave.</b>				d. STREET ADDRESS <b>1414 UNDERWOOD STREET, N.W.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) <b>DR. SAMUEL</b> <span style="float: right;">First Middle Last</span> <b>FISHMAN</b>				<b>4. DATE OF DEATH</b> <span style="float: right;">Month Day Year</span> <b>MAY 30 19 56</b>			
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>DEC. 6, 1908</b>		<b>9. AGE</b> (In years last birthday) <b>47</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>PHYSICIAN</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>NEW YORK</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>
<b>13. FATHER'S NAME</b> <b>LOUIS FISHMAN</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>HANNAH HENDEL</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <span style="float: right;">Address</span> <b>Mrs. Tillie Fishman, 1414 Underwood St., N.W. Washington, D.C.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO							INTERVAL BETWEEN ONSET AND DEATH <b>suicide</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> <span style="float: right;">Month, Day, Year</span> Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <b>Frank J. Broschart</b> <span style="float: right;">M.D.</span>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <b>Frank J. Broschart</b>				<b>DATE SIGNED</b> <b>5-30-56</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>June 1, 1956</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Adas Israel Cemetery</b>		<b>22d. LOCATION (City, town, or county) (State)</b> <b>Washington, D.C.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>B. Dargansky &amp; Son 3501-14 St NW</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE 6/5/56</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Charles Potter</b>	

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only a preliminary report is necessary, please execute in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05263

5285

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>MONTGOMERY</u>		STATE <u>MARYLAND</u>		COUNTY <u>MONTGOMERY</u>			
CITY (If outside corporate limits, write <u>RURAL</u> and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write <u>RURAL</u> and give nearest town)			
TOWN <u>BETHESDA</u>		<u>2 1/2 YRS.</u>		TOWN <u>BETHESDA</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>5202 WESTWOOD DRIVE</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>WILLIAM FREDERICK FOSHAG</u>				<u>MAY 21 1956</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, (MARRIED), WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<u>MALE</u>	<u>WHITE</u>		<u>MAR. 17, 1894</u>	<u>62</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>SCIENTIST</u>		<u>US GOVT</u>		<u>NEW YORK</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>WILLIAM F. FOSHAG</u>				<u>EVA REIGLER</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>NO</u>		<u>NONE</u>		<u>MERLE FOSHAG</u> <u>5202 WESTWOOD DRIVE</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Myocardial infarction</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary hypertension</u>						<u>Days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Essential hypertension</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, lecture, of INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> ....., 1952....., to <u>5/21</u> ....., 19 <u>56</u> ....., that I last saw the deceased alive on <u>5/16/</u> ....., 19 <u>56</u> ....., and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>5/21/56</u> (State)	
M.D. <u>900 - 17th St., N.W.</u>							
<b>23. BURIAL, CREMATION, or other disposal (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b>	
<u>Cremation</u>		<u>5/23/1956</u>		<u>Cedar Hill Crematory</u>		<u>Suitland, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>5-25-56</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>WASH. DC.</u>	

by: J. E. [Signature]

# CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD.

REG. NO. 100-100

1. NAME OF DECEASED (PRINT OR TYPE)

2. SEX (M or F) DATE OF BIRTH (Month, Day, Year)

3. PLACE OF BIRTH (City, State, Country)

4. DATE OF DEATH (Month, Day, Year)

5. TIME OF DEATH (Hour, Minute)

6. PLACE OF DEATH (City, State, Country)

7. CAUSE OF DEATH (Print or Type)

8. MANNER OF DEATH (Print or Type)

9. SIGNATURE OF PHYSICIAN (Print or Type)

10. SIGNATURE OF REGISTRAR (Print or Type)

11. SIGNATURE OF WITNESS (Print or Type)

12. SIGNATURE OF DECEASED (Print or Type)

13. SIGNATURE OF DECEASED (Print or Type)

14. SIGNATURE OF DECEASED (Print or Type)

15. SIGNATURE OF DECEASED (Print or Type)

16. SIGNATURE OF DECEASED (Print or Type)

17. SIGNATURE OF DECEASED (Print or Type)

BUREAU V. S.

MAY 29 1956

RECEIVED

PHOTOGRAPH

5250

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>3 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>502 Dean Drive</u>				d. STREET ADDRESS <u>502 Dean Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>JEWETT</u> Last <u>FOSTER</u>				4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 22-1905</u>	9. AGE (In years last birthday) yrs. <u>51</u>	IF UNDER 1 YEAR Months <u>2</u> Day <u>26</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Sta. Attend.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Gas Station</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Edward Foster</u>				14. MOTHER'S MAIDEN NAME <u>Nanette Jewett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-03-3267</u>		17. INFORMANT <u>W.B. Markham Stepson</u>		Address <u>Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion &amp; myocardial infarct.</u> DUE TO (c) <u>coronary arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>1 week</u> <u>Indef</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>2/1</u> , 19 <u>54</u> , to <u>5/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/18</u> , 19 <u>56</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen M. Jones</u> M.D.				ADDRESS (Street, city or town, state) <u>Rockville, Md.</u>		DATE SIGNED <u>5/19/56</u>	
PHYSICIAN'S NAME (Type) <u>Stephen M. Jones</u>				<u>Rockville, Md.</u>		<u>5/19/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-21-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>5/21/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Laurel Kratochvil per EC.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 22 1956

RECEIVED



5236

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>47x-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>13 Washington San Hospital</u>		d. STREET ADDRESS <u>2801 31st St. S.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mr Robert</u> Middle <u>Berle</u> Last <u>Frazier</u>		4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26 1905</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Health Educ. + Welfare Dpt. (clerk)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Indiana</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Novel L. Frazier</u>		14. MOTHER'S MAIDEN NAME <u>Luella Graham</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW #2</u>		16. SOCIAL SECURITY NO. <u>16-00-2</u>	
17. INFORMANT <u>Hospital records -</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> DUE TO (b) <u>Thrombophlebitis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs 45 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of bladder</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/12</u> , 19 <u>56</u> , to <u>5/12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/12</u> , 19 <u>56</u> , and that death occurred at <u>4:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur J. Willets</u>		ADDRESS (Street, city or town, state) <u>909 Pershing Drive, Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Arthur J. Willets</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>5/15/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>		24a. REC'D BY REGISTRAR <u>5/14/56</u>	
ADDRESS <u>2901-14th St. NW Washington, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Willets</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

MAY 15 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5286

### CERTIFICATE OF DEATH

05266

Reg. Dist. No. 215

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>4hr.34 min.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Pr. Geo.</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>4525 Buchanan Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary</u> <u>Anna</u> <u>GIBBARD</u>				<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>23</u> Year <u>1956</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>5-23-56</u>		<b>9. AGE</b> (In years last birthday) yrs. <u>4</u> <u>34</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Infant</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Bethesda, Maryland</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>				<b>13. FATHER'S NAME</b> <u>Foy Wallace GIBBARD</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Catherine Virginia CARTER</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>- -</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>None</u>				<b>17. INFORMANT</b> <u>(Father) Foy Wallace GIBBARD (Same As #2)</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x Prematurity</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 1/2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> <u>00</u> <u>00</u> p. m.			
<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> _____ (County) _____ (State) _____				<b>21. I certify that I attended the deceased from</b> <u>23 May</u> , 19 <u>56</u> , to <u>23 May</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>23 May</u> , 19 <u>56</u> , and that death occurred at <u>9:35 P.M.</u> from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <u>J.W. Stohlgman III (M.C.) USNR</u> <span style="float: right;">ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u></span>				<b>DATE SIGNED</b> <u>5-24-56</u>			
<b>PHYSICIAN'S NAME (Type)</b> <u>J.W. STOHLMAN, III, LT, MC, USNR</u> <span style="float: right;">U.S. Naval Hospital, Bethesda, Md.</span>				<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>			
<b>22b. DATE THEREOF</b> <u>5-26-56</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln Cemetery</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Washington, D. C.</u> (State) _____				<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>F. Fidler</u> <span style="float: right;">ADDRESS <u>Hyattsville, Md.</u></span>			
<b>Francis GASCH'S Sons</b> 4739 Baltimore Ave.,				<b>24a. REC'D BY REGISTRAR</b> <u>4-23-56</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Mary E. Cassally</u>				<b>25. I certify that the deceased was executed within 2 hours after death.</b>			

2051294XV0

BUREAU V. 1

MAY 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Items 8: & 9: Film G198  
6/6/56 dmr. 5287

CERTIFICATE OF DEATH

Reg. Dist. No. 95267

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>6 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7810 Moreland Lane</u>		d. STREET ADDRESS <u>7810 Moreland Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>WILLIAM</u> Last <u>GIERBERG</u>		4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-11-1888</u> <u>1878</u>
9. AGE (In years) <u>167</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>14</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Gustav Giersberg</u>		14. MOTHER'S MAIDEN NAME <u>Anna Yanke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>058-04-4372</u>	
17. INFORMANT <u>Kathryn S. Power, Dau. Item 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Starvation - Coma -</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral-Vascular Accident -</u> DUE TO (c) <u>Cardiovascular Disease -</u>		INTERVAL BETWEEN ONSET AND DEATH - <u>2 weeks -</u> <u>2 weeks -</u> <u>1st Attack 1952.</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma - Prostate - &amp; Metastasis - to Pelvis - Spine - Lungs -</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>23 Jan -</u> , <u>1952</u> , to <u>25 May</u> , <u>1956</u> , that I last saw the deceased alive on <u>14 May</u> , <u>1956</u> , and that death occurred at <u>7 a. m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John G. Ball</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>7936 Georgetown Rd.</u> <u>25 May 56</u>	
PHYSICIAN'S NAME (Type) <u>John G. Ball</u>		<u>Bethesda 14 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		22b. DATE THEREOF <u>5-26-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Pleasantville N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>5-28-56</u>		24b. REGISTRAR'S SIGNATURE <u>Beau M. Thompson</u>	



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF CORONER		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF CLERGYMAN	

Cardiovascular Disease  
Coronary Artery Disease  
Myocardial Infarction  
Atherosclerosis  
Hypertension  
Diabetes Mellitus  
Chronic Kidney Disease  
Cerebrovascular Disease  
Stroke  
Heart Failure  
Arrhythmia  
Angina Pectoris  
Coronary Artery Bypass Grafting  
Catheterization  
Percutaneous Coronary Intervention  
Coronary Stenting  
Coronary Artery Disease  
Myocardial Infarction  
Atherosclerosis  
Hypertension  
Diabetes Mellitus  
Chronic Kidney Disease  
Cerebrovascular Disease  
Stroke  
Heart Failure  
Arrhythmia  
Angina Pectoris  
Coronary Artery Bypass Grafting  
Catheterization  
Percutaneous Coronary Intervention  
Coronary Stenting

BUREAU V. 2

MAY 29 1956

RECEIVED

5288

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		d. STREET ADDRESS <i>9213 Columbia Blvd</i>	
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>William</i> Last <i>Gill</i>		4. DATE OF DEATH Month <i>May</i> Day <i>12</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN. 28 1906</i>
9. AGE (In years last birthday) <i>50</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lawyer</i>		10b. KIND OF BUSINESS, OR INDUSTRY <i>Private Practice</i>	
11. BIRTHPLACE (State or foreign country) <i>Mississippi</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wirt Alvin Gill</i>		14. MOTHER'S MAIDEN NAME <i>MARCEY Stevens</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>578-09-3763</i>	
17. INFORMANT <i>MRS. Ruth R. Gill</i>		Address <i>9213 Columbia Blvd Silver Spring, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>583X Hepatitis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary Heart Disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 mo.</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>April 10, 1956</i> to <i>May 12, 1956</i> , that I last saw the deceased alive on <i>May 12, 1956</i> , and that death occurred at <i>12:45</i> M., from the causes and on the date stated above. — ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Marion Bankhead</i> M.D.		9241 Col. Blvd. 5/14/56	
PHYSICIAN'S NAME (Type) <i>J. Marion Bankhead</i>		<i>Silver Spring, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 15, 1956</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Rockville Union Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Rockville, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner C. Pumphrey</i>		ADDRESS <i>Silver Spring, Md.</i>	
24a. REC'D BY REGISTRAR <i>5/16/56</i>		24b. REGISTRAR'S SIGNATURE <i>Mrs. Bevie Thompson</i>	

MEDICAL CERTIFICATION

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4

ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 16 1956

RECEIVED

5289

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SHARON CHRONIC HOSP</u>		d. STREET ADDRESS <u>10406 Ga. Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>Gleason</u> Last <u>May</u>		4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4, 1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Charles W. Cramer</u>		14. MOTHER'S MAIDEN NAME <u>Martha Biggs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Tomagni, 10406 Ga. Ave Wheaton Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma stomach - far advanced gen. metastatic</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>34 YEARS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June 22, 1955</u> to <u>May 31, 1956</u> , that I last saw the deceased alive on <u>May 24, 1956</u> , and that death occurred at <u>6:05 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Bosley Ziegler</u> M.D.		ADDRESS (Street, city or town, state) <u>Olney Md</u> DATE SIGNED <u>May 31, 1956</u>	
PHYSICIAN'S NAME (Type) <u>John Bosley Ziegler</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/2/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. 2901-14 St NW</u>		24a. REC'D BY REGISTRAR <u>5-31-56</u> 24b. REGISTRAR'S SIGNATURE <u>Kertrud B. Lawler</u>	

1  
After death: Page 4  
The law requires that the death certificate be executed within 2  
by the hospital or attending physician.  
CTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. BROWN</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>1910</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Engineer</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>1935</i>		9. PLACE OF MARRIAGE <i>St. Louis, Mo.</i>		10. NAME OF SPOUSE <i>Elizabeth A. Brown</i>		11. DATE OF DEATH <i>1956</i>		12. PLACE OF DEATH <i>Home</i>	
13. CAUSE OF DEATH <i>Heart Disease</i>		14. MANNER OF DEATH <i>Natural</i>		15. MEDICAL HISTORY <i>None</i>		16. SURVIVAL <i>Yes</i>		17. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		18. SIGNATURE OF DECEASED <i>John J. Brown</i>	
19. SIGNATURE OF WITNESS <i>John J. Brown</i>		20. SIGNATURE OF WITNESS <i>Elizabeth A. Brown</i>		21. SIGNATURE OF WITNESS <i>John J. Brown</i>		22. SIGNATURE OF WITNESS <i>Elizabeth A. Brown</i>		23. SIGNATURE OF WITNESS <i>John J. Brown</i>		24. SIGNATURE OF WITNESS <i>Elizabeth A. Brown</i>	

BUREAU V. 2

JUN 5 1956

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5290

## CERTIFICATE OF DEATH

Reg. Dist. No. 05270

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> b. COUNTY <b>COUNTY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Baby Boy</b> Middle <b>GOODINE</b> Last <b>GOODINE</b>				4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10 May 1956</b>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months <b>2</b> Days <b>2</b> Hours <b></b> Min. <b></b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>Infant</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Robert GOODINE, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Lois Gladys ADAMS (S)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>(Mother) Lois G. GOODINE (Same As #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PERICARDIAL EFFUSION</b> 754.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>INTERVENTRICULAR SEPTAL DEFECT</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>12 HRS</b> <b>2 DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>10 May</b> , 19 <b>56</b> , to <b>12 May</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>12 May</b> , 19 <b>56</b> , and that death occurred at <b>3:07 P.M.</b> from the causes and on the date stated above.							
ACTUAL PHYSICIAN <b>J. W. STOLHMAN, III, LT, MC, USN</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, NNMC, Bethesda, Md. 5-14-56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>5-16-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>	
				22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>CHINN Funeral Home 2605 Seminary Rd. Arl. Va.</b>				24a. REC'D BY REGISTRAR <b>DATE 5-14-56</b>		24b. REGISTRAR'S SIGNATURE <b>May E. Cassell</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051191XV6

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF BURIAL		PLACE OF BURIAL		CITY	
MAY 16 1968		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		MAY 18 1968		BALTIMORE		BALTIMORE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF OFFICIAL	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

MAY 16 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5291 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 18, 20, 21 Film GI 96 0-0-50 and

05271  
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5420 Goldsboro Rd.</u>		d. STREET ADDRESS <u>Goldsboro Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Eunice</u> Middle <u>C.</u> Last <u>Goodwin</u>		4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 19, 1924</u>
9. AGE (In years last birthday) <u>31</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>27</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel A. Clayton</u>		14. MOTHER'S MAIDEN NAME <u>Amye Purcell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Leo Goodwin- Item # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>973.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carbon monoxide poisoning</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found dead in garage with door closed, motor had been running.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5/17/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-19-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>5-21-56</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
MAY 24 1956  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05272

5292

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>9518 Colesville Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>L. Eopold J. Guggenberger</u>				4. DATE OF DEATH <u>5-25-56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/31/1879</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salesman</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leopold Guggenberger</u>				14. MOTHER'S MAIDEN NAME <u>Scottha Kumpf</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>330-26-4337</u>			
17. INFORMANT <u>Emily J. Rinschede</u>				Address <u>Bronx N.Y.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Hypertensive Heart Disease</u> (b) <u>Nephritis</u> DUE TO <u></u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>4 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec 1942</u> , to <u>May 25, 1956</u> , that I last saw the deceased alive on <u>May 14, 1956</u> , and that death occurred at <u>3:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John N. Andrew</u> M.D.				ADDRESS (Street, city or town, state) <u>960 Colesville Rd</u>			
PHYSICIAN'S NAME (Type) <u>John N. Andrews M.D.</u>				DATE SIGNED <u>5-25-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/28/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Bronx N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Chambers Co</u>				ADDRESS <u>1400 Phalanx St N.W.</u>		24a. REC'D BY REGISTRAR <u>5/29/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Francis</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

2995

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		HUSBAND'S OCCUPATION		MOTHER'S MARRIAGE	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		LABORER		LABORER		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH	
JUN 4 1968		BALTIMORE		MD		UNITED STATES		UNITED STATES		HEART DISEASE		NATURAL		1	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. 3

JUN 4 1968

RECEIVED

1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05273

## CERTIFICATE OF DEATH

5251

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY		Montgomery		STATE		D.C. COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		Rockville		CITY (If outside corporate limits, write RURAL and give nearest town)		Washington	
TOWN		4 mo		TOWN		47X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
Congressional Manor Sanit. 12201 Rockville Pike				4304 18th St. N.W.			
3. NAME OF DECEASED (Type or Print)		(First)		(Middle)		(Last)	
Gertrude				Gustafson			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
female		white		married		3/3/1866	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
housewife		at home		Virginia			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph Kelley				unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
no				-		Sanitarium records	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A)						Hypostatic Pneumonia	
ANTECEDENT CAUSE(S) DUE TO (B)						Cardiac Decompensation	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						Arteriosclerotic Heart Disease	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						Diabetes Mellitus	
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
				None			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> el/work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
None							
22. I hereby certify that I attended the deceased from July 24, 1941, to May 11, 1956, that I last saw the deceased alive on May 10, 1956, and that death occurred at 3:20 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Glen Pincock				1944 Seminary Rd Silver Spring		5/11/56	
M.D.							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
burial		5/14/56		Union Cemetery		Leesburg, Virginia	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 10/14/56		Laurel H. Kraylor		2901 14th St. N.W., Wash. D.C.		The S.H.Hines Co.	

# CERTIFICATE OF DEATH

Form 10-1-1934

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Age (Years and months)

4. Date of birth (Month, day, year)

5. Place of birth (City, State, Country)

6. Usual residence (City, State, Country)

7. Date of death (Month, day, year)

8. Time of death (Hour, minute)

9. Cause of death (Immediate cause)

10. Cause of death (Underlying cause)

11. Cause of death (Contributing cause)

12. Signature of physician (Print name)

13. Signature of physician (Write name)

14. Signature of physician (Write name)

15. Signature of physician (Write name)

16. Signature of physician (Write name)

17. Signature of physician (Write name)

18. Signature of physician (Write name)

19. Signature of physician (Write name)

20. Signature of physician (Write name)

21. Signature of physician (Write name)

22. Signature of physician (Write name)

23. Signature of physician (Write name)

24. Signature of physician (Write name)

25. Signature of physician (Write name)

26. Signature of physician (Write name)

27. Signature of physician (Write name)

28. Signature of physician (Write name)

29. Signature of physician (Write name)

30. Signature of physician (Write name)

31. Signature of physician (Write name)

32. Signature of physician (Write name)

33. Signature of physician (Write name)

34. Signature of physician (Write name)

35. Signature of physician (Write name)

BUREAU Y. S.

MAY 15 1936

RECEIVED

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5237

## CERTIFICATE OF DEATH

05274

Reg. Dist. No.

273

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>11 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>8 Walnut St., N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>Florence</u> Last <u>Hackett</u>		4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1956</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-02</u>		9. AGE (In years last birthday) <u>54 yrs.</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Chicago, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Stokke</u>				14. MOTHER'S MAIDEN NAME <u>Maria Ryerson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>Washington Sanitarium &amp; Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest with myocardial failure</u> 584X DUE TO <u>Post-operative shock</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO <u>Hypertensive vascular disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs 40 min</u> <u>30 min</u> <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Cholecystitis + cholelithiasis GB removed 5-11-56 at 6:30 PM</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no injury</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/10/56</u> to <u>5/12/56</u> , that I last saw the deceased alive on <u>5/10/56</u> , and that death occurred at <u>12:10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2731 Carroll St NW</u> DATE SIGNED <u>5/16/56</u> ACTUAL SIGNATURE <u>Frank L. Willman</u> M.D. PHYSICIAN'S NAME (Type) <u>Frank L. Willman</u> <u>Washington DC</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit Burial</u>		22b. DATE THEREOF <u>May 15, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beachgrove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St NW</u>		24a. REC'D BY REGISTRAR DATE <u>5/17/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. Arthur Walters</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 14 1956

RECEIVED



5293

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <b>Montg</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. LENGTH OF STAY IN 1b <b>12yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>	
		d. STREET ADDRESS <b>7- Montg.Ave</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Emily</b> Middle <b>W. Lyddane</b> Last <b>Hall</b>		4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 21-1884</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>16</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home Work</b>	
11. BIRTHPLACE (State or foreign country) <b>Montg Co. Md,</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William J. Williams</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth A Schaeffer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT Address <b>Virginia Darby. Gaithersburg. Md,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of pancreas</b> DUE TO <b>with generalized metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5-1</b> , 19 <b>56</b> , to <b>5-7</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5-6</b> , 19 <b>56</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank J. Broschert</b>		M.D. <b>Gaithersburg Md 5-8-56</b>	
PHYSICIAN'S NAME (Type) <b>FRANK J. Broschert</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-10-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>	22d. LOCATION (City, town, or county) (State) <b>Beallsville. Md,</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner,</b>		ADDRESS <b>Gaithersburg.Md,</b>	
24a. REC'D BY REGISTRAR DATE <b>May 9-56</b>		24b. REGISTRAR'S SIGNATURE <b>Abner L. Cooke</b>	

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5294

## CERTIFICATE OF DEATH

05276

214

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>MONTGOMERY</b>		STATE <b>MARYLAND</b>		COUNTY <b>MONTGOMERY</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>9525 THORNHILL ROAD</b>				STREET ADDRESS (If rural give location) <b>9525 THORNHILL ROAD</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>FANNIE M HALLEY</b>				<b>4. DATE OF DEATH</b> (Month) <b>MAY</b> (Day) <b>19</b> (Year) <b>19 56</b>			
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>WIDOWED</b>	<b>8. DATE OF BIRTH</b> <b>JULY 1, 1867</b>		<b>9. AGE last birthday</b> <b>88</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER - RETIRED</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>WASHINGTON, D.C.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>
<b>13. FATHER'S NAME</b> <b>CHARLES JAMES</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>SUSAN HUTCHISON</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>577-18-6743-D</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mr. Eugene Halley, 9525 Thornhill Rd. Silver Spring, Md.</b>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>443X IMMEDIATE CAUSE (A)</b> <b>Uremia</b>						<b>2 weeks</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Hypertensive Cardio-renal vascular disease</b>						<b>10 yrs</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b> <b>Senility</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Diabetes Mellitus</b>						<b>1-2 yrs</b>	
<b>Chronic Pharyngitis</b>						<b>3 yrs</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from May 14, 1956, to May 19, 1956, that I last saw the deceased alive on May 18, 1956, and that death occurred at 11:30 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>Lester W. Harris</b>				<b>ADDRESS</b> (Street, city, town, state) <b>1011 Coatesville Rd Silver Spring Md</b>		<b>DATE SIGNED</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>BURIAL</b>		<b>DATE THEREOF</b> <b>5/22/56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>CONGRESSIONAL CEMETERY</b>		<b>LOCATION (City, town, or county) (State)</b> <b>WASHINGTON, D.C.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>5/24/56</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Francis P. Lott</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Warner E. Humphrey</b>		<b>ADDRESS</b> <b>SILVER SPRING, MD.</b>	

# CERTIFICATE OF DEATH

233

1956

1. NAME OF DECEASED

NAME AND

ADDRESS OF

DECEASED

DATE OF

DEATH

PLACE OF

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CAUSE OF

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BUREAU W. S.

MAY 28 1956

RECEIVED

5295

## CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Woodfield</b>				c. LENGTH OF STAY IN lb <b>10 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. Gaithersburg</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Viola Virginia Hamilton</b>				4. DATE OF DEATH Month Day Year <b>May 12 1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13, 1874</b>	9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joshua Stup</b>				14. MOTHER'S MAIDEN NAME <b>L. Virginia Zimmerman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Earl Hamilton, Gaithersburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>18 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 15, 1951</b> , to <b>May 12, 1956</b> , that I last saw the deceased alive on <b>May 10, 1956</b> , and that death occurred at <b>9:00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James P. Kerr</b> M.D.				ADDRESS (Street, city or town, state) <b>Damascus, Md.</b>		DATE SIGNED <b>5/14/56</b>	
PHYSICIAN'S NAME (Type) <b>James P. Kerr M.D.</b>				<b>Damascus, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 15, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Woodfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Moberworth</b>				ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>May 14/56</b>	
						24b. REGISTRAR'S SIGNATURE <b>Della H. Burdette</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

MAY 16 1956

BUREAU V. S.

*[Faint, mostly illegible text, possibly a signature or official stamp]*

Rural - Woodfield		Rural - Woodfield	
R. B. D. Galtersburg		R. B. D. Galtersburg	
Virginia Hamilton		Virginia Hamilton	
May 12 1956		May 12 1956	
61		61	
Rosenfield		Rosenfield	
Galtersburg		Galtersburg	
Frederick Co., Md.		Frederick Co., Md.	
USA		USA	
L. Virginia Hamilton		L. Virginia Hamilton	
Earl Hamilton, Galtersburg, Md.		Earl Hamilton, Galtersburg, Md.	

CERTIFICATE OF DEATH

1956

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

5296

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>md</b> b. COUNTY <b>montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Alta Vista Rest Home</b>			d. STREET ADDRESS <b>3712 Bradley La</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Elizabeth Agnes HAND</b>			4. DATE OF DEATH <b>May 31, 1956</b>		
5. SEX <b>F</b>			6. COLOR OR RACE <b>W</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>Oct 12, 1892</b>		
9. AGE (In years last birthday) <b>63</b> yrs.			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>6</b> Days <b>3</b> Hours <b>3</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>		
11. BIRTHPLACE (State or foreign country) <b>Illinois</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John Muller</b>			14. MOTHER'S MAIDEN NAME <b>Agnes Brown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>--</b>			16. SOCIAL SECURITY NO. <b>No</b>		
17. INFORMANT <b>John Hand</b>			Address <b>Ch. Ch. Md. 3618 Raymond St.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Left Ventricular Failure</b> <b>443X</b> DUE TO <b>acute Pulmonary Edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerotic</b> DUE TO <b>Hypertensive Heart disease</b> (c) <b>Hypertensive Heart disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)			20g. (County)		20h. (State)
21. I certify that I attended the deceased from <b>June 1954</b> , to <b>May 31, 1956</b> , that I last saw the deceased alive on <b>5-31-56</b> , and that death occurred at <b>12:05</b> M. from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) <b>4201 Fessenden St. N.W. Washington</b>					
DATE SIGNED <b>5-31-56</b> <b>V.C.</b>					
ACTUAL PHYSICIAN'S NAME (Type) <b>P. P. ANDREWS M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 6-8-56</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>The Pines</b>	
22d. LOCATION (City, town, or county) <b>Opportunity</b>		(State) <b>Wash</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda Md.</b>		24a. REC'D BY REGISTRAR <b>5-31-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be detached and filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is partially filled out with handwritten text.

BUREAU V. 2

JUN 5 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05279 214

Reg. Dist. No.

5297

1. PLACE OF DEATH a. COUNTY <u>Montg</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>11 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>102212 Washington Ave</u>				d. STREET ADDRESS <u>2212 Washington Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Caroline Elizabeth Harkins</u> First Middle Last				4. DATE OF DEATH <u>May 24 1956</u> Month Day Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-3-1918</u>		9. AGE (In years last birthday) <u>37</u> yr.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S C</u>	
13. FATHER'S NAME <u>John P Aiderhold</u>				14. MOTHER'S MAIDEN NAME <u>Grace Salhada</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>206-10-7512</u>		17. INFORMANT Address <u>Richard Harkins (husband) Same as Dec. 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>Fatal death in bed</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bradford Co. Mem. Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Luther Mills, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>5/29/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>			

TO DECEASED: This certificate should be executed within 24 hours after death. If any necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
JUN 4 1956  
BUREAU V. S.



## CERTIFICATE OF DEATH

Reg. Dist. No. 214

5298

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>4 yrs</u>				d. STREET ADDRESS <u>1923 - East West Hwy</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1923 - East West Hwy</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Katherine T HEFFNER</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN, 30</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> Hours <u>19</u> Min. <u>56</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NW Hampshire</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael O'Malley</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Teresa</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>H. C. Edwards, Edward P. Heffner</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>antihypertensive</u> DUE TO (c) <u>antihypertensive</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>May</u> , 19 <u>54</u> , to <u>May 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 6</u> , 19 <u>56</u> , and that death occurred at <u>7:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Helen J. de S. Coutinho</u> M.D. <u>1890 - Ontario PR. N.W. Wash. D.C.</u>							
PHYSICIAN'S NAME (Type) <u>HELEN J. de S. COUTINHO</u> <u>1890 ONTARIO PL. N.W. - WASH. D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5-9-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Agnes</u>		22d. LOCATION (City, town, or county) (State) <u>St. Agnes - DC</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stanley Taylor - 3831 - Ga. Ave. NW</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Stanley Taylor</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

MAY 9 1956

RECEIVED

5299

CERTIFICATE OF DEATH

05281  
Reg. Dist. No. 246

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>		d. STREET ADDRESS <b>none</b>	
3. NAME OF DECEASED (Type or print) First <b>Bette</b> Middle <b>Annette</b> Last <b>Hensley</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 1, 1949</b>
9. AGE (In years last birthday) <b>6</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Hensley</b>		14. MOTHER'S MAIDEN NAME <b>Bette Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>intra-cranial hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>bronchopneumonia</b> DUE TO (c) <b>acute lymphocytic leukemia</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 30, 1956</b> to <b>May 10, 1956</b> , that I last saw the deceased alive on <b>May 10, 1956</b> , and that death occurred at <b>1:00 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Mehran Goulia</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>5/10/56</b>	
PHYSICIAN'S NAME (Type) <b>Mehran Goulia</b> M. D.		<b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-13-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Eventide Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Spencer W. Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR <b>5-11-56</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

05282/4

Reg. Dist. No.

5300

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
c. LENGTH OF STAY IN 1b <u>16 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1909 LANSDOWNE WAY</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month <u>MAY</u> Day <u>4</u> Year <u>1956</u>			
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>KNOWLES</u> Last <u>HESLET</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 14, 1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BENJAMIN LACEY KNOWLES</u>		14. MOTHER'S MAIDEN NAME <u>RHODA ANN LONGSHORE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MARY R. HESLET</u>		Address <u>1909 LANSDOWNE WAY SILVER SPRING</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension Arterio</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 2, 1956</u> to <u>May 4, 1956</u> that I last saw the deceased alive on <u>May 3, 1956</u> , and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3066 - Capital Hill, Md.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>E. Stuart Lyman</u> PHYSICIAN'S NAME (Type) <u>E. STUART LYMAN</u> <u>Working town D.C.</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial May 12, 1956</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town or county) (State) <u>Southland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Lee's Sons 300-4 2nd</u>		24a. REC'D BY REGISTRAR <u>5/7/56</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Francis Toller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Received May 12, 1956  
J. William Jones, Jr. 300 4th St.

RECEIVED

MAY 9 1956

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05283

Reg. Dist. No. 223

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.5em;">5238</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Montgomery</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P.G.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>7204 13th AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Robert William</u> <u>Harold</u> <u>Hoch</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>May</u> <u>26</u> <u>1956</u>											
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Cauc</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8/18/51</u>		<b>9. AGE</b> (In years last birthday) <u>4</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 MRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 MRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 MRS.														
Months	Days														
Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>Amer</u>							
<b>13. FATHER'S NAME</b> <u>Charles Hoch</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Georgia Mae Hoch</u>											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>---</u>		<b>17. INFORMANT</b> <u>mother</u> <u>Takoma Park Police Dept.</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Bullet wound through chest</u> (c) <u>919.0</u> stating the underlying cause lost. DUE TO								INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>shot self while playing with pistol</u>											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>7:45</u> <u>6</u> <u>am</u> <u>5/26</u> <u>1956</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> (County) (State) <u>Takoma Park P. G. Co. Md.</u>							
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> , <b>Inspection</b> <input checked="" type="checkbox"/> , <b>Inquiry</b> <input checked="" type="checkbox"/> , and find that death resulted from: <b>Noturol causes</b> <input type="checkbox"/> , <b>Accident</b> <input checked="" type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined cause</b> <input type="checkbox"/> .															
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <u>5/26 /56</u>							
<b>EXAMINER'S NAME (Type)</b> <u>Frank J. Broschart</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>May 29, 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Prince Georges Co. Md.</u>									
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur Talley</u>				<b>ADDRESS</b> <u>254 Carroll St.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>5/26/56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>John Deady</u>							

TO DIE: This certificate should be executed within 24 hours after death. If only necessary, please execute the certificate in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ALABAMA STATE DEPARTMENT OF HEALTH-BIRMINGHAM 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 1

MAY 31 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5301

CERTIFICATE OF DEATH

05284  
 Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norbeck</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bradford Rest Home</u>				d. STREET ADDRESS <u>May August 1956</u>			
3. NAME OF DECEASED (Type or print) <u>Eliza E. Hopkins</u>				4. DATE OF DEATH <u>May August 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 26 1862</u>	9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Prestley Aukward</u>				14. MOTHER'S MAIDEN NAME <u>Lavinia Hill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Robert Hopkins - Sandy Spring, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac incompetency</u> DUE TO (c) <u>Hypertensive Cardiorenal Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinsonian Syndrome</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 10, 1950</u> , to <u>May 6, 1956</u> , that I last saw the deceased alive on <u>May 6, 1956</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Webster Sewell</u> M.D.				ADDRESS (Street, city or town, state) <u>Norbeck Rd Silver Spring, Md</u>			
DATE SIGNED <u>5-8-56</u>							
PHYSICIAN'S NAME (Type) <u>WEBSTER SEWELL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/9/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sumner</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>5-6-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Gertude B Lawler</u>			

# CERTIFICATE OF DEATH

1930

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

<p>NAME OF DECEASED</p>		<p>AGE</p>		<p>SEX</p>		<p>RACE</p>		<p>DATE OF BIRTH</p>		<p>PLACE OF BIRTH</p>	
<p>RESIDENCE</p>		<p>DATE OF DEATH</p>		<p>PLACE OF DEATH</p>		<p>Cause of Death</p>		<p>Immediate Cause</p>		<p>Underlying Cause</p>	
<p>Signature of Physician</p>		<p>Signature of Registrar</p>		<p>Signature of Coroner</p>		<p>Signature of Medical Examiner</p>		<p>Signature of Health Officer</p>		<p>Signature of County Clerk</p>	

BUREAU V. S.

MAY 14 1956

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

052853

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>26 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>7717 Carroll Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Calvin</u> Middle <u>Taylor</u> Last <u>Hudson</u>		<b>4. DATE OF DEATH</b> Month <u>5</u> Day <u>-3</u> Year <u>1956</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Nov-12-55</u>		<b>9. AGE</b> (In years last birthday) <u>53</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.																				
Months	Days																				
	Hours																				
	Min.																				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Barber</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>											
<b>13. FATHER'S NAME</b> <u>John A. J. Hudson</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Elizabeth Rodney</u>															
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>222-03-4644</u>				<b>17. INFORMANT</b> <u>Hospital Records</u>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>Short - Subdural Hemorrhage &amp; 816X</u>  <b>DUE TO</b> <u>Cerebral contusion</u>  <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> </td> <td rowspan="2" style="vertical-align: top;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>25 hrs</u> </td> </tr> <tr> <td colspan="2"> <b>DUE TO</b> <u>Fracture of skull (left parietal)</u> </td> </tr> </table>												<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Short - Subdural Hemorrhage &amp; 816X</u> <b>DUE TO</b> <u>Cerebral contusion</u> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>25 hrs</u>	<b>DUE TO</b> <u>Fracture of skull (left parietal)</u>						
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Short - Subdural Hemorrhage &amp; 816X</u> <b>DUE TO</b> <u>Cerebral contusion</u> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>25 hrs</u>																			
<b>DUE TO</b> <u>Fracture of skull (left parietal)</u>																					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>																					
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>He drove a car which ran thru stop sign &amp; struck by other car</u>																	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>5-2-1956</u> Hour <u>10</u> a. m. <u>5</u> p. m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>street</u>		<b>20f. (City or town)</b> <u>Takoma Park</u> (County) <u>Montgomery</u> (State) <u>Md</u>													
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																					
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschert</u> <b>M.D.</b>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>															
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschert</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>															
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						<b>DATE SIGNED</b> <u>5-4-56</u>															
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>				<b>22b. DATE THEREOF</b> <u>5/7/56</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>EVERGREEN</u>													
<b>22d. LOCATION (City, town, or county)</b> <u>BERLIN</u>				<b>(State)</b> <u>MD</u>																	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Anna R. Burbage Berlin</u>						<b>24a. REC'D BY REGISTRAR</b> <u>MAY 8 1956</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>J. Nelson Ladd</u>													

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 8 1956

RECEIVED

5302

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>120 Quincy Street</u>				d. STREET ADDRESS <u>120 QUINCY STREET</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>NONE</u> Last <u>HUGHES</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 24, 1881</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BRICKLAYER-CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BRICK-CONTRACTOR</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS HUGHES</u>				14. MOTHER'S MAIDEN NAME <u>HARRIET MANDER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>SON-DONALD HUGHES 120 QUINCY ST.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 ACUTE MYOCARDIAL INFARCTION</u> DUE TO (b) <u>CORONARY ARTERY DISEASE</u> DUE TO (c) <u>UNDETERMINED</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 WEEKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>27 May, 1956</u> , to <u>27 May, 1956</u> , that I last saw the deceased alive on <u>27 May, 1956</u> , and that death occurred at <u>11 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph L. Linn</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>BETHESDA 14 MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>5/31/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wash, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>5-30-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>	
The S.H.Hines Co., 2901 14th St. N.W.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. JONES		2. SEX Male	
3. AGE 45		4. RACE White	
5. DATE OF DEATH June 1, 1956		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural	
9. SIGNATURE OF PHYSICIAN J. J. Jones		10. SIGNATURE OF REGISTRAR J. J. Jones	
11. SIGNATURE OF DECEASED J. J. Jones		12. SIGNATURE OF WITNESSES J. J. Jones	
13. SIGNATURE OF FUNERAL HOME J. J. Jones		14. SIGNATURE OF BURIAL PLACE J. J. Jones	
15. SIGNATURE OF INTERVIEWER J. J. Jones		16. SIGNATURE OF INTERVIEWER J. J. Jones	
17. SIGNATURE OF INTERVIEWER J. J. Jones		18. SIGNATURE OF INTERVIEWER J. J. Jones	
19. SIGNATURE OF INTERVIEWER J. J. Jones		20. SIGNATURE OF INTERVIEWER J. J. Jones	
21. SIGNATURE OF INTERVIEWER J. J. Jones		22. SIGNATURE OF INTERVIEWER J. J. Jones	
23. SIGNATURE OF INTERVIEWER J. J. Jones		24. SIGNATURE OF INTERVIEWER J. J. Jones	
25. SIGNATURE OF INTERVIEWER J. J. Jones		26. SIGNATURE OF INTERVIEWER J. J. Jones	
27. SIGNATURE OF INTERVIEWER J. J. Jones		28. SIGNATURE OF INTERVIEWER J. J. Jones	
29. SIGNATURE OF INTERVIEWER J. J. Jones		30. SIGNATURE OF INTERVIEWER J. J. Jones	
31. SIGNATURE OF INTERVIEWER J. J. Jones		32. SIGNATURE OF INTERVIEWER J. J. Jones	
33. SIGNATURE OF INTERVIEWER J. J. Jones		34. SIGNATURE OF INTERVIEWER J. J. Jones	
35. SIGNATURE OF INTERVIEWER J. J. Jones		36. SIGNATURE OF INTERVIEWER J. J. Jones	
37. SIGNATURE OF INTERVIEWER J. J. Jones		38. SIGNATURE OF INTERVIEWER J. J. Jones	
39. SIGNATURE OF INTERVIEWER J. J. Jones		40. SIGNATURE OF INTERVIEWER J. J. Jones	
41. SIGNATURE OF INTERVIEWER J. J. Jones		42. SIGNATURE OF INTERVIEWER J. J. Jones	
43. SIGNATURE OF INTERVIEWER J. J. Jones		44. SIGNATURE OF INTERVIEWER J. J. Jones	
45. SIGNATURE OF INTERVIEWER J. J. Jones		46. SIGNATURE OF INTERVIEWER J. J. Jones	
47. SIGNATURE OF INTERVIEWER J. J. Jones		48. SIGNATURE OF INTERVIEWER J. J. Jones	
49. SIGNATURE OF INTERVIEWER J. J. Jones		50. SIGNATURE OF INTERVIEWER J. J. Jones	
51. SIGNATURE OF INTERVIEWER J. J. Jones		52. SIGNATURE OF INTERVIEWER J. J. Jones	
53. SIGNATURE OF INTERVIEWER J. J. Jones		54. SIGNATURE OF INTERVIEWER J. J. Jones	
55. SIGNATURE OF INTERVIEWER J. J. Jones		56. SIGNATURE OF INTERVIEWER J. J. Jones	
57. SIGNATURE OF INTERVIEWER J. J. Jones		58. SIGNATURE OF INTERVIEWER J. J. Jones	
59. SIGNATURE OF INTERVIEWER J. J. Jones		60. SIGNATURE OF INTERVIEWER J. J. Jones	
61. SIGNATURE OF INTERVIEWER J. J. Jones		62. SIGNATURE OF INTERVIEWER J. J. Jones	
63. SIGNATURE OF INTERVIEWER J. J. Jones		64. SIGNATURE OF INTERVIEWER J. J. Jones	
65. SIGNATURE OF INTERVIEWER J. J. Jones		66. SIGNATURE OF INTERVIEWER J. J. Jones	
67. SIGNATURE OF INTERVIEWER J. J. Jones		68. SIGNATURE OF INTERVIEWER J. J. Jones	
69. SIGNATURE OF INTERVIEWER J. J. Jones		70. SIGNATURE OF INTERVIEWER J. J. Jones	
71. SIGNATURE OF INTERVIEWER J. J. Jones		72. SIGNATURE OF INTERVIEWER J. J. Jones	
73. SIGNATURE OF INTERVIEWER J. J. Jones		74. SIGNATURE OF INTERVIEWER J. J. Jones	
75. SIGNATURE OF INTERVIEWER J. J. Jones		76. SIGNATURE OF INTERVIEWER J. J. Jones	
77. SIGNATURE OF INTERVIEWER J. J. Jones		78. SIGNATURE OF INTERVIEWER J. J. Jones	
79. SIGNATURE OF INTERVIEWER J. J. Jones		80. SIGNATURE OF INTERVIEWER J. J. Jones	
81. SIGNATURE OF INTERVIEWER J. J. Jones		82. SIGNATURE OF INTERVIEWER J. J. Jones	
83. SIGNATURE OF INTERVIEWER J. J. Jones		84. SIGNATURE OF INTERVIEWER J. J. Jones	
85. SIGNATURE OF INTERVIEWER J. J. Jones		86. SIGNATURE OF INTERVIEWER J. J. Jones	
87. SIGNATURE OF INTERVIEWER J. J. Jones		88. SIGNATURE OF INTERVIEWER J. J. Jones	
89. SIGNATURE OF INTERVIEWER J. J. Jones		90. SIGNATURE OF INTERVIEWER J. J. Jones	
91. SIGNATURE OF INTERVIEWER J. J. Jones		92. SIGNATURE OF INTERVIEWER J. J. Jones	
93. SIGNATURE OF INTERVIEWER J. J. Jones		94. SIGNATURE OF INTERVIEWER J. J. Jones	
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97. SIGNATURE OF INTERVIEWER J. J. Jones		98. SIGNATURE OF INTERVIEWER J. J. Jones	
99. SIGNATURE OF INTERVIEWER J. J. Jones		100. SIGNATURE OF INTERVIEWER J. J. Jones	

BUREAU V. S.

JUN 1 1956

RECEIVED

5240

CERTIFICATE OF DEATH

05287 1/13

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park, MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14 days Pasadena 02X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>Rock Hill Beach</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Elma</u> Middle <u>Elsie</u> Last <u>Hyland</u>				4. DATE OF DEATH Month <u>5-</u> Day <u>28-</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-19-1902</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>28</u> Hours <u>19</u> Min. <u>56</u>		IF UNDER 24 HRS. Months <u>5</u> Days <u>28</u> Hours <u>19</u> Min. <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Parks</u>				14. MOTHER'S MAIDEN NAME <u>Marytus Landon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Washington Sanitarium &amp; Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>002X Tuberculous bronchopneumonia</u> DUE TO (b) <u>Chronic ulcerative tuberculosis, lung</u> DUE TO (c) <u>several yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>14 May</u> , 19 <u>56</u> , to <u>28 May</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>28 May</u> , 19 <u>56</u> , and that death occurred at <u>12:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas H Wolohin</u> M.D.				ADDRESS (Street, city or town, state) <u>5100 Underwood St NW 5/28/56</u> DATE SIGNED <u>Wash DC</u>			
PHYSICIAN'S NAME (Type) <u>Chas H Wolohin</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>May 31/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sharon Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Sharon Burnie MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Singleton Funeral Home</u> ADDRESS <u>Sharon Burnie Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 6 1956</u>		24b. REGISTRAR'S SIGNATURE <u>G. Halson Dadds</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

REG. NO. 111

1. NAME OF DECEASED <i>Charles William [illegible]</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. RACE <i>White</i>		5. PLACE OF BIRTH <i>London, England</i>	
6. DATE OF DEATH <i>June 6, 1956</i>		7. TIME OF DEATH <i>10:15 AM</i>		8. PLACE OF DEATH <i>Home</i>		9. CAUSE OF DEATH <i>Chronic [illegible]</i>		10. MANNER OF DEATH <i>Natural</i>	
11. SIGNATURE OF DECEASED <i>[Signature]</i>		12. SIGNATURE OF WITNESS <i>[Signature]</i>		13. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		14. SIGNATURE OF CORONER <i>[Signature]</i>		15. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
16. NAME OF PHYSICIAN <i>[illegible]</i>		17. NAME OF CORONER <i>[illegible]</i>		18. NAME OF REGISTRAR <i>[illegible]</i>		19. NAME OF WITNESS <i>[illegible]</i>		20. NAME OF DECEASED <i>[illegible]</i>	

BUREAU V. S.

JUN 6 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5303

## CERTIFICATE OF DEATH

05288216  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Maryland</b> c. LENGTH OF STAY IN 1b <b>23 days</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>		d. STREET ADDRESS <b>1341 A Street, N. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Annie Marie Johnson</b>		4. DATE OF DEATH <b>May 4, 1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 26, 1900</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Household duties</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Marshall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>not available</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Paroxysmal Atrial Flutter</b> <b>141X</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Metastatic Carcinoma Lung</b> DUE TO (c) <b>Carcinoma of Tongue</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 11, 1956</b> , to <b>May 4, 1956</b> , that I last saw the deceased alive on <b>May 4, 1956</b> , and that death occurred at <b>1 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ted Clemens, Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-8-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Charles County Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Montgomery Bros.</b> ADDRESS <b>913-Fla. Ave. NW</b>		24a. REC'D BY REGISTRAR <b>DATE 16-56</b>	
		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

BUREAU V. S.

MAY 22 1956

RECEIVED

534  
CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Norbeck</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bradford Rest Home</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Spring</b>	
		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>Carrie Johnson</b> First Middle Last		4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>1956</b>	
5. SEX <b>femal</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12, 1873</b>
		9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>
13. FATHER'S NAME <b>George Dorsey</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <b>Robert A. Johnson</b> Address <b>Sandy Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Hepatic and Colon</b> <b>199.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Cardiorenal D. Arthritis Herpes Zoster</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1953</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 26, 1936</b> , to <b>May 18, 1956</b> , that I last saw the deceased alive on <b>May 17, 1956</b> , and that death occurred at <b>7:50 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Webster Sewell</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Webster Sewell, M.D.</b>		<b>Norbeck Rt. 1 Silver Spring</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/21/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sandy Spring,</b>	22d. LOCATION (City, town, or county) (State) <b>Sandy Springs, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Sworden</b>		ADDRESS <b>Rockville, Md.</b>	
24a. REC'D BY REGISTRAR <b>5-23-56</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur B. Law</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be furnished by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05290

Reg. Dist. No. 216

5305

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring B-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Francis Amanda Johnson</u>				4. DATE OF DEATH Month Day Year <u>July 2 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-30-1894</u>	
9. AGE (in years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Elmer Mathews</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Stewart</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Catharine Sedgwick (daughter)</u>		Address <u>same as dec'd</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>420.1</u> DUE TO (c) <u>420.1</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 hr.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/5/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wood Hope</u>		22d. LOCATION (City, town, or county) (State) <u>Colesville, md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden - Rockville md</u>		24a. REC'D BY REGISTRAR <u>5-7-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>		24c. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		24d. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		24e. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

MEDICAL CERTIFICATION

2

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other necessary, please enclose a copy of this certificate with the body, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

RECEIVED

MAY 9 1956

BUREAU V. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05291

5306

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>District of Columbia</b> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	c. LENGTH OF STAY IN 1b <b>26 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>1200 "O" Street, N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thomasena</b> Middle <b>(none)</b> Last <b>Johnson</b>		4. DATE OF DEATH Month <b>May</b> Day <b>20</b> , Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 23, 1905</b>
9. AGE (In years lost birthday) yrs. <b>50</b>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Household duties</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samson Peoples</b>		14. MOTHER'S MAIDEN NAME <b>Anneta Persons</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-40-2542</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of breast - metastatic</b> <b>170X</b> DUE TO to axillary lymph nodes, mediastinal lymph nodes, abdominal lymph nodes and brain (b) <b>lymph nodes</b> (c) <b>and brain</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 24, 1956</b> , to <b>May 20, 1956</b> , that I last saw the deceased alive on <b>May 20, 1956</b> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm. M. Headley</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>William M. Headley, M.D.</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>5-21-56</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Wm. L. C.</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chas. F. Allen</b> ADDRESS <b>1200 9th Ave. N. W.</b>		24a. REC'D BY REGISTRAR <b>DATE 5-22-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

CERTIFICATE OF DEATH

NAME OF DECEASED MONTGOMERY		AGE 30 years		SEX Male		RACE White	
DATE OF DEATH September 23, 1905		PLACE OF DEATH Baltimore, Md.		CITY Baltimore		COUNTY Baltimore	
CAUSE OF DEATH (To be filled by physician)		DISEASE OR INJURY (To be filled by physician)		MANNER OF DEATH (To be filled by physician)		PLACE OF BURIAL (To be filled by physician)	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

MAY 24 1956

RECEIVED

5307

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>1 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SHARON CRONIC HOSP.</u>				d. STREET ADDRESS <u>7400 Bradley Blvd</u>			
3. NAME OF DECEASED (Type or print) First <u>Eleanor</u> Middle <u>Karsten</u> Last <u>Karsten</u>				4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 3, 1891</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>56</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Indianapolis Ind.</u>				12. CITIZEN OF WHAT COUNTRY? <u>American</u>			
13. FATHER'S NAME <u>Charles E. Cox</u>				14. MOTHER'S MAIDEN NAME <u>Emma Mason Cooley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>##</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>####</u>		17. INFORMANT <u>Mrs Karl Karsten</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatoid arthritis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs.</u> <u>17 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>April 9, 1935</u> to <u>May 7, 1956</u> , that I last saw the deceased alive on <u>April 28, 1956</u> , and that death occurred at <u>6:40 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Katharine A. Chapman</u> M.D. <u>3934 Baltimore St.</u>				<u>May 7, 1956</u>			
PHYSICIAN'S NAME (Type) <u>KATHARINE ACHADMAN</u>				<u>Kensington, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>May 7, 1956</u>		<u>Fort Lincoln</u>		<u>Prince George Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u>				ADDRESS <u>Laytonville, Ind.</u>		24a. REC'D BY REGISTRAR <u>5-9-56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Towle</u>	

TO HOSTS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

BUREAU V. S.

MAY 15 1956.

RECEIVED

Item 9, Film 198 6-14-56 et

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND <i>Co</i>	STATE <i>Maryland</i>	COUNTY <i>Mont.</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Olney</i>	LENGTH OF STAY (in this place) <i>4 yrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Olney</i> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>none</i>		STREET ADDRESS (If rural give location) <i>1</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<i>Mary Ozella Kengla</i>		<i>May 28 1956</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE MARRIED. WIDOWED, DIVORCED. (Specify): <i>Widow</i>	8. DATE OF BIRTH: <i>Sept 26, 1875</i>
9. AGE last birthday: <i>80</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>at home</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>—</i>	
11. BIRTHPLACE (State or foreign country): <i>Washington DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Lewis Schneider</i>		14. MOTHER'S MAIDEN NAME: <i>Mary Ozella Ellis</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>no</i>		16. SOCIAL SECURITY NO.: <i>no</i>	
17. INFORMANT & ADDRESS: <i>Mr. Lewis R. Kengla</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
153X IMMEDIATE CAUSE (A) <i>Carcinoma of Colon</i>			<i>1 yr</i>
ANTECEDENT CAUSE (S) DUE TO (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>Dec</i> , 1955, to <i>May</i> , 1956, that I last saw the deceased alive on <i>May 27</i> , 1956, and that death occurred at <i>1:45 PM</i> , from the causes and on the date stated above.			
SIGNATURE <i>A.D. Bonifant</i>		DATE SIGNED <i>5/28/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>May 31/56</i>	
NAME OF CEMETERY OR CREMATORY <i>Parklawn</i>		LOCATION (City, town, or county) (State) <i>Rockville Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>5-28-56</i>		24. FUNERAL DIRECTOR <i>Adams Funeral Home</i>	
REGISTRAR'S SIGNATURE <i>Gertrude B. Lawler</i>		ADDRESS <i>4746 Wisconsin Ave. N.W.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 1 1956

BUREAU V. 3

Handwritten notes and signatures, including "Mary Ogden", "George", and "1852".

5399  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN lb <b>134 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>4306 Tuckerman Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Malcolm</b> Middle <b>Henderson</b> Last <b>Kerr</b>				4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 7, 1901</b>	
9. AGE (In years last birthday) yrs. <b>54</b>		IF UNDER 1 YEAR Months <b>16</b> Days <b>19</b> Hours <b>56</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Professor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>University</b>	
11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Charles M. Kerr</b>		14. MOTHER'S MAIDEN NAME <b>Annie Dodge</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>550-09-2173</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Insufficiency and Uremia</b> <b>289.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Primary Generalized Amyloidosis</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>January 3, 1956</b> to <b>May 16, 1956</b> , that I last saw the deceased alive on <b>May 16, 1956</b> , and that death occurred at <b>1:45 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John T. Binion</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>May 16, 1956</b>			
PHYSICIAN'S NAME (Type) <b>John T. Binion, M. D.</b>				National Institutes of Health <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 18, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Maryland</b>			
24a. REC'D BY REGISTRAR <b>MAY 21 1956</b>				24b. REGISTRAR'S SIGNATURE <b>Mary E. Fanelly</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		January 1, 1901		Baltimore, Md.		Natural		Heart Disease		January 15, 1956		10:00 AM		Home		J. A. Smith, M.D.		J. B. Jones, Registrar	

BUREAU V. S.

MAY 21 1956

RECEIVED



5310

## CERTIFICATE OF DEATH

05295

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DC.</u> b. COUNTY <u>47X-3</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>29 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4726 Reno Road</u>	
3. NAME OF DECEASED (Type or print) <u>Arthur Sixtus Kettler</u>		4. DATE OF DEATH <u>MAY 22 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 7 1890</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Examiner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Interstat Commerce</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK Kettler</u>		14. MOTHER'S MAIDEN NAME <u>HARRIET BEIER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>mes. Thelma Kettler</u>	
17. INFORMANT <u>mes. Thelma Kettler</u>		Address <u>4726 Reno Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Coronary Artery Thrombosis</u> DUE TO <u>Coronary Artery Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>1 Mo.</u> <u>1 Mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 23, 1956</u> to <u>May 22, 1956</u> that I last saw the deceased alive on <u>May 21, 1956</u> , and that death occurred at <u>7:50 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert H. Havell</u>		ADDRESS (Street, city or town, state) <u>5516 Neb. Ave. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Robert H. Havell</u>		DATE SIGNED <u>5/22/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>5/24/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co., 2901 14th St. N.W.</u>		ADDRESS <u>Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>5-24-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5311

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>2745-29th St, N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Michael</u> Last <u>Kirby</u>		4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1876</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>12</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Kirby</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Flemming</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>006-10-4886</u>	
17. INFORMANT <u>John J. Kirby, 609 Knollwood Dr.</u>		Address <u>Falls Church, Va.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-Vascular - Renal Disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from <u>May 5</u> , 19 <u>56</u> , to <u>May 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 15</u> , 19 <u>56</u> , and that death occurred at <u>2:35 P.M.</u> from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>Sidney E. Cousins</u> M.D. <u>3921 Longview St NW 5/15/56</u>		DATE SIGNED
PHYSICIAN'S NAME (Type) <u>SIDNEY E. COUSINS</u>		<u>Wash DC</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-18-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>
22d. LOCATION (City, town, or county) <u>Washington</u>		(State) <u>D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>
24a. REC'D BY REGISTRAR <u>5-16-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

NOTES

BUREAU V. S.

MAY 21 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5312 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05297

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>12604 Holdridge Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>William Roger Knight</u>		4. DATE OF DEATH <u>May 17 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-14-1923</u>
9. AGE (In years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter and Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contracting Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Howard Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Roger Knight</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Elizabeth Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>214-12-7996</u>	
17. INFORMANT <u>Sister</u>		Address <u>Spencerville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO (b) <u>Abdominal Hemorrhage</u> DUE TO (c) <u>Crushed Pelvis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>31 hrs.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Crushed while attempting to load bulletproof on a tractor</u>	
20c. TIME OF INJURY Hour <u>11:15</u> a. m. <u>5-16</u> 19 <u>56</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>	20f. (City or town) <u>Bethesda</u> (County) <u>Montg</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/21/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. BURIAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>MAY 21 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

TO DECEASED: This certificate should be executed within 24 hours after death. If any other person, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



BUREAU V. 3

MAY 21 1956

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**5313**  
**CERTIFICATE OF DEATH**

**05298**

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>			c. LENGTH OF STAY IN 1b <b>6 MO. 10 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SHARON CHRONIC HOSPITAL</b>				d. STREET ADDRESS <b>9916 ROGART ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SOPHIA</b> Middle <b>LOUISE</b> Last <b>KOHR</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>17</b> Year <b>19 56</b>					
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 31, 1870</b>		9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SOCIAL SERVICE WORKER</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MANSFIELD, PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>DANIEL DOTY</b>				14. MOTHER'S MAIDEN NAME <b>ESTER HOLLY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>579-12-5069D</b>		17. INFORMANT Address <b>MR. H. G. BRUNK, 9916 Rogart Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>493X</b> DUE TO <b>Pneumonia (Recurrent)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>5 weeks</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 1955</b> , to <b>May 17 1956</b> , that I last saw the deceased alive on <b>May 13 1956</b> , and that death occurred at <b>11:25 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>John N. Andrews</b> ADDRESS (Street, city or town, state) <b>9601 Colesville Rd Silver Spring Md</b> DATE SIGNED <b>May 17-56</b> PHYSICIAN'S NAME (Type) <b>John N. Andrews M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/21/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL MEM. PARK CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>FALLS CHURCH, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b> ADDRESS <b>SILVER SPRING, MD.</b>				24a. REC'D BY REGISTRAR <b>MAY 21 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Gertrude B. Lawley</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 21 1956

RECEIVED

5314

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>47X3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN lb <u>15 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Monty Co. Gen. Hosp</u>		d. STREET ADDRESS <u>438 10th St. N.E.</u>	
3. NAME OF DECEASED (Type or print) <u>Roger Edger Lancaster</u>		4. DATE OF DEATH <u>May 20 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-27-1954</u>
9. AGE (In years last birthday) <u>2</u>		10. IF UNDER 1 YEAR Days <u>20</u> Hours <u>1956</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Roger Lancaster</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Prather</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Pauline Prather (mother)</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhagic stroke of brain (pt. positive)</u> 10 mo 902.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture of skull 7-6-55</u> (c) <u>—</u> DUE TO cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from porch at home to concrete basement</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>7-6 1955</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Washington DC</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		DATE SIGNED <u>5-20-56</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>May 23 56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brookgrove md</u>	22d. LOCATION (City, town, or county) (State) <u>Lortonville md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W Barber Lortonville md</u>		24a. REC'D BY REGISTRAR <u>5-28-56</u>	24b. REGISTRAR'S SIGNATURE <u>Kenneth B Lawler</u>

TO DECEASED: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only one signature is necessary, please execute and file, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 1 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5315

CERTIFICATE OF DEATH

05300

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN IB <b>40 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harvey</b> Middle <b>Holt</b> Last <b>Langley, Jr.</b>				4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 31, 1946</b>	
9. AGE (In years last birthday) <b>9</b> yrs.		IF UNDER 1 YEAR Months <b>9</b> Days <b>15</b> Hours <b>19</b> Min. <b>56</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School boy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Harvey Langley</b>				14. MOTHER'S MAIDEN NAME <b>Alta Riley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastro-intestinal hemorrhage</b> <b>204.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute lymphocytic leukemia</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>OB. coli + Klebsiella septemia</b> (b) <b>bronchopneumonia RLL RUL LLL</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Wilson County, No. Car.</b>				20g. (State) <b>Wilson County, No. Car.</b>			
21. I certify that I attended the deceased from <b>April 5</b> , 19 <b>56</b> , to <b>May 15</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>May 15</b> , 19 <b>56</b> , and that death occurred at <b>11:00A</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>May 15, 1956</b>							
ACTUAL SIGNATURE <b>Arthur G. Ship, M.D.</b>				PHYSICIAN'S NAME (Type) <b>Arthur G. Ship, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 5-17-56</b>				22b. DATE THEREOF <b>5-17-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Grove Cem.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>T.W. Cobb</b>				ADDRESS <b>Elm City, No. Car.</b>		24a. REC'D BY REGISTRAR <b>5-16-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>							

# CERTIFICATE OF DEATH

MAINTAIN STATE OF HEALTH - BATHING IS

Name of Deceased		Date of Birth		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Harvey Isaacson		1915		Male		White		Jewish		Married		Teacher		Heart Disease		Home		May 15, 1956		10:30 AM		[Signature]		[Signature]		[Signature]	
Place of Birth		Date of Death		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
New York City, New York		May 15, 1956		Male		White		Jewish		Married		Teacher		Heart Disease		Home		May 15, 1956		10:30 AM		[Signature]		[Signature]		[Signature]	
Place of Birth		Date of Death		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
New York City, New York		May 15, 1956		Male		White		Jewish		Married		Teacher		Heart Disease		Home		May 15, 1956		10:30 AM		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

MAY 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05301

5316

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>South Charleston</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>				d. STREET ADDRESS <b>826 Jefferson Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Gerald</b> Middle <b>Everett</b> Last <b>Lanier</b>				4. DATE OF DEATH Month <b>May</b> Day <b>9</b> Year <b>56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 3, 1946</b>	
9. AGE (In years last birthday) yrs. <b>9</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
13. FATHER'S NAME <b>Donald Lanier</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Possible intracerebral hemorrhage</b> <b>2040</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute lymphocytic leukemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 8, 1956</b> , to <b>May 9, 1956</b> , that I last saw the deceased alive on <b>May 9, 1956</b> , and that death occurred at <b>9:05 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Martin Schick</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>5/9/56</b>			
PHYSICIAN'S NAME (Type) <b>Martin Schick, M. D.</b>				The National Institutes of Health <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial-Transit 5-12-56</b>		<b>Graceland Mem. Park.</b>		<b>Kanawha Co., West Virginia.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. D. Degnan</b> ADDRESS <b>South Charleston, West Virginia</b>				24a. REC'D BY REGISTRAR <b>5-11-56</b>		24b. REGISTRAR'S SIGNATURE <b>Bernie M. Thompson</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 531 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05302

Reg. Dist. No. 216

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3611 Sheppard St</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> d. STREET ADDRESS <u>3611 Sheppard St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Emma Riggs Ledy</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>May 1 1956</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Jan. 20, 1882</u>		<b>9. AGE</b> (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR: Months <u>3</u> Days <u>11</u> IF UNDER 24 HRS.: Hours <u>11</u> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housework</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Ill.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>? Riggs</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>? Stacey</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>578-07-8179</u>		<b>17. INFORMANT</b> Address <u>Mrs J. Reynolds Smith, Sr. - Item # 2</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>								<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschait</u> M.D.					<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschait</u>					<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					<b>DATE SIGNED</b> <u>5-1-56</u>				
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>			<b>22b. DATE THEREOF</b> <u>5-4-56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>George Washington</u>			<b>22d. LOCATION</b> (City, town, or county) (State) <u>Prince George Co., Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>Robert A. Pumphrey-Bethesda, Md.</u>						<b>24a. REC'D BY REGISTRAR</b> DATE <u>5/3/56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

2

TO DIE: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

MAY 7 1956

RECEIVED

5318

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY BETHESDA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	c. LENGTH OF STAY IN 1b <u>11 DAYS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE (29)</u> <u>034-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CLINICAL CENTER, NIH</u>		d. STREET ADDRESS <u>5419 WHITLOCK ROAD</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ALMA</u> Middle <u>ELIZABETH</u> Last <u>LEE</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 2, 1920</u>
9. AGE (In years last birthday) yrs. <u>35</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>HARRY B. BLANCHARD</u>	
14. MOTHER'S MAIDEN NAME <u>ALMA SWANN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>215-09-8514</u>		17. INFORMANT <u>THE MEDICAL RECORD</u> Address <u>THE CLINICAL CENTER, BETHESDA 14 MARYLAND</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HODGKINS DISEASE</u> <u>201X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>BETHESDA 14 MARYLAND</u>
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>APRIL 24</u> , 19 <u>56</u> , to <u>MAY 5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>MAY 5</u> , 19 <u>56</u> , and that death occurred at <u>9:40 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>BETHESDA 14 MARYLAND</u> DATE SIGNED <u>5/6/56</u>		
ACTUAL SIGNATURE <u>Martin Schick</u> M.D. <u>THE CLINICAL CENTER</u> <u>THE NATIONAL INSTITUTES OF HEALTH</u> <u>BETHESDA 14 MARYLAND</u>		
PHYSICIAN'S NAME (Type) <u>MARTIN SCHICK M.D.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAY 9, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>
22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry A. Witzke</u> ADDRESS <u>4101 EDMONDSON AVE</u>		24a. REC'D BY REGISTRAR <u>MAY 8</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Mrs. Bessie Thompson</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5319

## CERTIFICATE OF DEATH

05304

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> OR TOWN <u>25 days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>D.C.</u> COUNTY <u>✓</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> OR TOWN <u>47X-3</u> STREET ADDRESS (If rural give location) <u>6135 30th St. N.W.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Katherine Mattern Lewis</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 9 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 9, 1896</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. rigton, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Mattern</u>				14. MOTHER'S MAIDEN NAME <u>Christine Dill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Christine Mattern - Sister 6135-30th St, N.W. Wash.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>25 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Arteriosclerosis</u>						<u>5 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 19 57</u> to <u>May 9 19 56</u> , that I last saw the deceased alive on <u>May 8, 19 56</u> , and that death occurred at <u>5:20 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert M. Thompson</u>		M.D. <u>5516 Nebraska Ave D.C.</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>5-9-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/11/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>L. H. Hines</u>		ADDRESS <u>2901 14th NW Wash. D.C.</u>	
DATE <u>5-10-56</u>							

# CERTIFICATE OF DEATH

1956 MAY 14

1. NAME OF DECEASED: [illegible]

2. SEX: [illegible] 3. AGE: [illegible]

4. DATE OF BIRTH: [illegible]

5. PLACE OF BIRTH: [illegible]

6. DATE OF DEATH: [illegible]

7. PLACE OF DEATH: [illegible]

8. CAUSE OF DEATH: [illegible]

9. MANNER OF DEATH: [illegible]

10. SIGNATURE OF PHYSICIAN: [illegible]

11. SIGNATURE OF REGISTRAR: [illegible]

12. SIGNATURE OF WITNESS: [illegible]

13. SIGNATURE OF DECEASED: [illegible]

14. SIGNATURE OF NEXT OF KIN: [illegible]

15. SIGNATURE OF CLERGYMAN: [illegible]

16. SIGNATURE OF BURIAL OFFICIAL: [illegible]

17. SIGNATURE OF INTERVIEWER: [illegible]

18. SIGNATURE OF INTERVIEWER: [illegible]

19. SIGNATURE OF INTERVIEWER: [illegible]

20. SIGNATURE OF INTERVIEWER: [illegible]

21. SIGNATURE OF INTERVIEWER: [illegible]

22. SIGNATURE OF INTERVIEWER: [illegible]

23. SIGNATURE OF INTERVIEWER: [illegible]

24. SIGNATURE OF INTERVIEWER: [illegible]

25. SIGNATURE OF INTERVIEWER: [illegible]

26. SIGNATURE OF INTERVIEWER: [illegible]

27. SIGNATURE OF INTERVIEWER: [illegible]

28. SIGNATURE OF INTERVIEWER: [illegible]

29. SIGNATURE OF INTERVIEWER: [illegible]

30. SIGNATURE OF INTERVIEWER: [illegible]

BUREAU V. 3

MAY 14 1956

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5320

## CERTIFICATE OF DEATH

05305

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>VIRGINIA</b> b. COUNTY <b>ARLINGTON</b> <b>83X-3</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X RURAL BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>18 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7 USNH, NMMC, BETHESDA, MARYLAND</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES CLIFTON LOVENBERG</b>		4. DATE OF DEATH Month Day Year <b>MAY 15 1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CA</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/26/26</b>
9. AGE (In years last birthday) yrs. <b>29</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>29</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RESEARCH CHEMIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BUORD USN</b>	
11. BIRTHPLACE (State or foreign country) <b>R.I.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CLIFTON LOVENBERG</b>		14. MOTHER'S MAIDEN NAME <b>FRANCES DARLING</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW-II</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>413 N. GEORGE MASON DR. ELNORA LOVENBERG ARLINGTON, VA.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, lobular</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Leukemia, granulocytic, Acute</b> DUE TO <b>Leukemia, granulocytic, Chronic</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>204.1</b> <b>2 days</b> <b>2 1/2 wks</b> <b>5 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 1/2 wks</b> <b>5 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>28 April</b> 19 <b>56</b> to <b>15 May</b> 19 <b>56</b> that I last saw the deceased alive on <b>15 May</b> 19 <b>56</b> and that death occurred at <b>6:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm. B. Ingram</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 5-16-56</b>	
PHYSICIAN'S NAME (Type) <b>William B. Ingram, CDR, MC, USN. U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>21 May 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Swan Point Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Providence, Rhode Island</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>4-16-56</b>	
ADDRESS <b>Bethesda, Md. 7557 Wisconsin Ave.</b>		24b. REGISTRAR'S SIGNATURE <b>May E. Parrelly</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAINE STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

MAY 17 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5321 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05306

Reg. Dist. No. 216

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Montgomery</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Dist. of Columbia</span> <span style="float: right;">b. COUNTY</span>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Chevy Chase</span>			c. LENGTH OF STAY IN 1b  			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Washington</span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">Chevy Chase Club</span>				d. STREET ADDRESS <span style="font-size: 1.2em;">2540 Mass. Ave. N.W.</span>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print)		First <span style="font-size: 1.2em;">THOMAS</span>		Middle <span style="font-size: 1.2em;">HIXON</span>		Last <span style="font-size: 1.2em;">LOWE</span>		<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">May</span> Day <span style="font-size: 1.2em;">19</span> Year <span style="font-size: 1.2em;">19 56</span>	
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>		<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">White</span>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">7-16-1879</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">76 yrs.</span>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">U.S. Army Ret.</span>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Govt.</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Missouri</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">William M. Lowe</span>				<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Barbara C. Williams</span>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> WW I & II				<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">No</span>		<b>17. INFORMANT</b> Address <span style="font-size: 1.2em;">Sarah I. Lowe, Wife Above Item #2</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="font-size: 1.5em;">Coronary occlusion</span> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">Sudden</span>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour <span style="font-size: 1.2em;">19</span> a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
<b>ACTUAL SIGNATURE</b> <span style="font-size: 1.2em;">Frank J. Broschart</span> <span style="float: right;">M.D.</span>					<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>EXAMINER'S NAME (Type)</b> <span style="font-size: 1.2em;">Frank J. Broschart</span>					<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					<b>DATE SIGNED</b> <span style="font-size: 1.2em;">5-19-56</span>				
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>		<b>22b. DATE THEREOF</b> <span style="font-size: 1.2em;">5-22-1956</span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Arlington Nat. Cem.</span>			<b>22d. LOCATION (City, town, or county)</b> (State) <span style="font-size: 1.2em;">Arlington Va.</span>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">Robert A. Pumphrey</span>				<b>ADDRESS</b> <span style="font-size: 1.2em;">Bethesda Md.</span>		<b>24a. REC'D BY REGISTRAR</b> <span style="font-size: 1.2em;">DATE 5-21-56</span>		<b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">Bernie M. Thompson</span>	

TO DIE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute and forward to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05307

5241

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. LENGTH OF STAY IN 1b <b>8 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>804 Maplewood Ave.</b>				d. STREET ADDRESS <b>804 Maplewood Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MAY</b> First Middle Last <b>LUCAS</b>				4. DATE OF DEATH <b>May</b> Month <b>10</b> Day <b>19</b> Year <b>56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 7, 1873.</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	
11. BIRTHPLACE (State or foreign country) <b>Long Island, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Rueben Arthur</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte PAINE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. O. E. Mathiason, Calonia, New Jersey</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Congestive Heart Failure</b> DUE TO <b>Coronary atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis with residual right hemiplegia</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>7-10 days</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1, 1956</b> , to <b>May 10, 1956</b> , that I last saw the deceased alive on <b>May 10, 1956</b> , and that death occurred at <b>5:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>5/10/56</b>							
ACTUAL SIGNATURE <b>Charles H. Wolohin</b> M.D.				PHYSICIAN'S NAME (Type) <b>Charles H. Wolohin</b> <b>500 Underwood St. N. W. Washington, D. C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>May 12, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Pr. Geo. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James J. Volohin</b> ADDRESS <b>Takoma Park, DC.</b>				24a. REC'D BY REGISTRAR <b>5/12/56</b>		24b. REGISTRAR'S SIGNATURE <b>J. Wilson Deak</b>	



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		FILE NO.	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		PREVIOUS DEATHS		PREVIOUS RECORDS	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		FILE NO.	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		PREVIOUS DEATHS		PREVIOUS RECORDS	

BUREAU V. S.

MAY 14 1956

RECEIVED

5242

CERTIFICATE OF DEATH

05308

Reg. Dist. No. 273

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. + Hosp.</u>		d. STREET ADDRESS <u>P.O. Box 7812 Ben Franklin Station</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Louis</u> Last <u>Luedtke</u>		4. DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 2, 1883</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>2</u> Hours <u>15</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Foreign Serviceman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Emily P. Cuergen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>603X</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 25</u> , 19 <u>56</u> , to <u>May 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 26</u> , 19 <u>57</u> , and that death occurred at <u>9:40 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. W. Whitlock</u>		ADDRESS (Street, city or town, state) <u>Wash. San + Hosp. Takoma Park</u>	
PHYSICIAN'S NAME (Type) <u>J. W. WHITLOCK</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>5/28/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Southland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Esq. 1400 Chapin St</u>		ADDRESS <u>Wash. San + Hosp. Takoma Park</u>	
24a. REC'D BY REGISTRAR <u>5/19/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dordick</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1953

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF MORTUARY		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL		19. SIGNATURE OF CREMATION		20. SIGNATURE OF OTHER			

BUREAU V. S.

MAY 31 1953

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**5322**  
**CERTIFICATE OF DEATH**

05309

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>8607 Lancaster Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Wilson</u> Last <u>Lyon</u>				4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-14-84</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oscar Lyon</u>				14. MOTHER'S MAIDEN NAME <u>M. Edna Hardenburg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Helene P. Lyon-Item# 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>Carcinoma - prostate or rectum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>154X</u> DUE TO (c) <u>3 mo</u> <u>10 yr</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 wk.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1936</u> to <u>May 5, 1956</u> , that I last saw the deceased alive on <u>May 5, 1956</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Nyrth Post Baker</u> M.D.				ADDRESS (Street, city or town, state) <u>1635 HARVARD ST. Wash. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>NYRTH POST BAKER</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>5/7/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 8-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1504

11/11/2012

BUREAU V. S.

MAY 11 1956

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5323

CERTIFICATE OF DEATH

05310

Reg. Dist. No. 266

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RUTH</b> Middle <b>ALMA</b> Last <b>MCGUINNESS</b>				4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 11, ?</b>	
9. AGE (In years last birthday) yrs. <b>57</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>30</b> Hours <b>19</b> Min. <b>56</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Reg. Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>018-12-6061</b>		17. INFORMANT <b>Ruth M. Aubrey, Daughter-Rockville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic heart disease</b> (c) <b>Hypertensive encephalopathy</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral vascular accident</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 19 55</b> to <b>5/30</b> 19 <b>56</b> that I last saw the deceased alive on <b>5/30</b> 19 <b>56</b> and that death occurred at <b>9:30</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles M. Weber</b> M.D.				DATE SIGNED <b>12600 ARKLAND DR Rockville Md</b>			
PHYSICIAN'S NAME (Type) <b>Charles M. Weber</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-2-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 5-8-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Beauregard M. Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2023

NAME OF DECEASED [Faint, illegible text]		SEX [Faint, illegible text]		AGE [Faint, illegible text]	
PLACE OF BIRTH [Faint, illegible text]		DATE OF BIRTH [Faint, illegible text]		TIME OF BIRTH [Faint, illegible text]	
PLACE OF DEATH [Faint, illegible text]		DATE OF DEATH [Faint, illegible text]		TIME OF DEATH [Faint, illegible text]	
CAUSE OF DEATH [Faint, illegible text]		MANNER OF DEATH [Faint, illegible text]		PLACE OF INTERMENT [Faint, illegible text]	
SIGNATURE OF PHYSICIAN [Faint, illegible text]		SIGNATURE OF REGISTRAR [Faint, illegible text]		SIGNATURE OF WITNESS [Faint, illegible text]	

BUREAU V. 2

JUN 5 1956

RECEIVED

5324

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>136 SOUTHWOOD AVE.</b>		d. STREET ADDRESS <b>136 SOUTHWOOD AVE.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>FLETCHER</b> Last <b>MERRICK</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>22</b> Year <b>19 56</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 11, 1889</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONDUCTOR (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PENNA. RAILROAD</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>BENJAMIN F. MERRICK</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET R. FLETCHER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>717-07-5882</b>	
17. INFORMANT <b>Mrs. Mary E. Merrick, 136 Wouthwood Ave. Silver Spring, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>with auricular Fibrillation</b> INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>4 years</b> <b>1 1/2 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>November 1954</b> , to <b>May 22, 1956</b> , that I last saw the deceased alive on <b>April 26, 1956</b> , and that death occurred at <b>7:10 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8801 Colesville Road., Silver Spring, Md.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Russell B. Arnold</b> M.D.			
PHYSICIAN'S NAME (Type) <b>RUSSELL B. ARNOLD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5/25/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>EAST NEW MARKET CEMETERY</b>	22d. LOCATION (City, town or county) (State) <b>EAST NEW MARKET, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>		ADDRESS <b>SILVER SPRING, MD.</b>	24a. REC'D BY REGISTRAR <b>DATE 5/29/56</b>
		24b. REGISTRAR'S SIGNATURE <b>Francis Potter</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

See 01. 11.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS		TENNESSEE		TENNESSEE		UNITED STATES OF AMERICA	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		CITY OF BURIAL	
MAY 14 1968		10:00 PM		MEMPHIS		TENNESSEE		TENNESSEE		UNITED STATES OF AMERICA		MAY 14 1968		MEMPHIS		TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		DIVORCED	
FIREARM WOUND TO THE CHEST		SUICIDE		ATTORNEY		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED		MARRIED	
PHYSICIAN'S SIGNATURE		DATE		HOSPITAL		CITY		STATE		COUNTRY		DATE		CITY		STATE	
JAMES EARL RAY		MAY 14 1968		MEMPHIS		TENNESSEE		TENNESSEE		UNITED STATES OF AMERICA		MAY 14 1968		MEMPHIS		TENNESSEE	
FAMILY PHYSICIAN'S SIGNATURE		DATE		FAMILY PHYSICIAN'S NAME		FAMILY PHYSICIAN'S ADDRESS		FAMILY PHYSICIAN'S CITY		FAMILY PHYSICIAN'S STATE		FAMILY PHYSICIAN'S COUNTRY		FAMILY PHYSICIAN'S ZIP		FAMILY PHYSICIAN'S PHONE	
JAMES EARL RAY		MAY 14 1968		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
CORONER'S SIGNATURE		DATE		CORONER'S NAME		CORONER'S ADDRESS		CORONER'S CITY		CORONER'S STATE		CORONER'S COUNTRY		CORONER'S ZIP		CORONER'S PHONE	
JAMES EARL RAY		MAY 14 1968		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DEATH CERTIFICATE NO.		DEATH CERTIFICATE NO.		DEATH CERTIFICATE NO.		DEATH CERTIFICATE NO.		DEATH CERTIFICATE NO.		DEATH CERTIFICATE NO.		DEATH CERTIFICATE NO.		DEATH CERTIFICATE NO.		DEATH CERTIFICATE NO.	
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BUREAU V. S.

JUN 4 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5325

### CERTIFICATE OF DEATH

05312

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>2601 Ross Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Webster</u> Last <u>Middleton</u>				4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24 1885</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Webster Middleton</u>				14. MOTHER'S MAIDEN NAME <u>Rosalee Rawlett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Mrs. Alma Groves - Sister Chevy Chase Rd</u>		Address <u>2601 Ross Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA, TERMINAL</u> DUE TO <u>181X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMATOSIS, GENERALIZED</u> DUE TO <u>4 MONTHS</u> (c) <u>CARCINOMA, PAPILLARY, BLADDER</u> <u>1 YEAR</u>							INTERVAL BETWEEN ONSET AND DEATH <u>21 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIO SCLEROSIS GENERALIZED</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC. 24</u> , 19 <u>55</u> , to <u>MAY 12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>MAY 11</u> , 19 <u>56</u> , and that death occurred at <u>8:10 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert G. Angle</u> M.D.				ADDRESS (Street, city or town, state) <u>5009 Del Ray Ave., Bethesda, Md.</u>			
DATE SIGNED <u>5/12/56</u>							
PHYSICIAN'S NAME (Type) <u>R. obert G. Angle</u>		5009 Del Ray Avenue, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Owens, King Geo. Co., Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Ryan, Inc. 317 Pa. Ave. S. E. D.C.</u>				24a. REC'D BY REGISTRAR <u>MAY 14 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Rosie M. Thompson</u>	



BUREAU V. S.

MAY 14 1956

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 218

5326

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quince Orchard</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Traveler</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Yakthuburg R-3</u>				d. STREET ADDRESS <u>Yakthuburg R-3</u>			
3. NAME OF DECEASED (Type or print) First <u>Celomo</u> Middle <u>Augustus</u> Last <u>Mitchell</u>				4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-9-05</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>5</u> Min. <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Peter Mitchell</u>				14. MOTHER'S MAIDEN NAME <u>Emma Imee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Imy Castile - Gaith. md R-3</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>148x Acute Cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Throat</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCART</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5/31/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Seneca</u>		22d. LOCATION (City, town, or county) (State) <u>Seneca, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Surnden - Rockville, md</u>				24a. REC'D BY REGISTRAR <u>DATE 5-31-56</u>		24b. REGISTRAR'S SIGNATURE <u>Whitely G. Cooke</u>	

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further action is necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO DISTRICT

DATE OF ENTRY INTO TOWN

DATE OF ENTRY INTO VILLAGE

DATE OF ENTRY INTO PARISH

DATE OF ENTRY INTO CHURCH

DATE OF ENTRY INTO SCHOOL

DATE OF ENTRY INTO EMPLOYMENT

DATE OF ENTRY INTO SERVICE

DATE OF ENTRY INTO DEATH

DATE OF ENTRY INTO BURIAL

DATE OF ENTRY INTO CREMATION

DATE OF ENTRY INTO INTERMENT

DATE OF ENTRY INTO REINTERMENT

DATE OF ENTRY INTO REINTERMENT

DATE OF ENTRY INTO REINTERMENT

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BUREAU V. S.

JUN 5 1956

RECEIVED

5327

## CERTIFICATE OF DEATH

Reg. Dist. No.

05314

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kenwood</u>				c. LENGTH OF STAY IN 1b <u>2 Mos</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6816 Millwood Road</u>				d. STREET ADDRESS <u>6816 Millwood Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>ELLA</u> Last <u>MITCHELL</u>				4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-27-1878</u>	
9. AGE (In years last birthday) yrs. <u>77</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>3</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Robert Mitchell</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Holleman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Dr. James S. Dryden-Son-in-law- Kenwood Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIO SCLEROSIS</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u> <u>10 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL VASCULAR ACCIDENT</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>DECEMBER</u> , 19 <u>55</u> , to <u>MAY 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>MAY 29</u> , 19 <u>56</u> , and that death occurred at <u>2:15 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1835 Eye St., N.W. Washington, D.C.</u> DATE SIGNED <u>May 30, 1956</u>							
ACTUAL SIGNATURE <u>Frederick W. Coe</u> M.D. <u>1835 Eye St., N.W. Washington, D.C.</u> <u>May 30, 1956</u>							
PHYSICIAN'S NAME (Type) <u>Frederick W. Coe</u> <u>1835 Eye St., N.W. Washington, D.C.</u> <u>May 30</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-1-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Aulander Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Aulander No. Car.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey,</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 6-30-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2527

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 67		4. DATE OF BIRTH 1888	
5. PLACE OF BIRTH BALTIMORE, MD		6. OCCUPATION LABORER		7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL	
9. PLACE OF DEATH BALTIMORE, MD		10. DATE OF DEATH JUN 1 1956		11. TIME OF DEATH 10:00 AM		12. SIGNATURE OF PHYSICIAN J. H. HARRIS	
13. SIGNATURE OF REGISTRAR J. H. HARRIS		14. SIGNATURE OF WITNESSES J. H. HARRIS		15. SIGNATURE OF FUNERAL HOME J. H. HARRIS		16. SIGNATURE OF CLERK J. H. HARRIS	

RECEIVED  
JUN 1 1956  
BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05315  
2/15

5328

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> c. LENGTH OF STAY IN 1b <u>2 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Monty Co. Gen. Hosp.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ashton</u> d. STREET ADDRESS <u>-----</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Hoyt</u> Middle <u>H.</u> Last <u>Morrison</u>		<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>12</u> Year <u>1956</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>2-17-22</u>		<b>9. AGE</b> (In years last birthday) <u>34</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Construction</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Tenn</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USC</u>									
<b>13. FATHER'S NAME</b> <u>E. M. Morrison</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Laura Huntland</u>															
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>WW #2</u>				<b>16. SOCIAL SECURITY NO.</b> <u>412-24-8247</u>				<b>17. INFORMANT</b> <u>Ruth Morrison (wife)</u> Address <u>same as decd.</u>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>Thoracic &amp; Abdominal Hemorrhage</u>  <u>825X</u>  <b>DUE TO</b>  <b>Conditions, if any, which gave rise to immediate cause (b)</b> <u>Internal Injuries</u>  <b>(c), stating the underlying cause last.</b> <u>A</u> </div>																					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Comp fracture left leg</u>																					
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input checked="" type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 1B.) <u>the driver of co. vehicle went out of control</u>																	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>5-12-1956</u> Hour <u>6:15</u> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>				<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>				<b>20f. (City or town)</b> <u>Chesley</u> <b>(County)</b> <u>Monty</u> <b>(State)</b> <u>md</u>									
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																					
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschait</u>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>															
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschait</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>															
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						<b>DATE SIGNED</b> <u>5-12-56</u>															
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Shipment</u>				<b>22b. DATE THEREOF</b> <u>May 15, 1956</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Sugar Creek Cemetery</u>				<b>22d. LOCATION (City, town, or county)</b> <u>Bradley County, Tennessee</u> <b>(State)</b>									
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner C. Humphrey</u>						<b>ADDRESS</b> <u>Silver Spring, Md.</u>															
<b>24a. REC'D BY REGISTRAR</b> <u>5/16/56</u>						<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Lewis</u>															

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any further action is necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
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37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
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49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
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85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

RECEIVED  
MAY 17 1956  
BUREAU V. S.

## CERTIFICATE OF DEATH

05316

Reg. Dist. No. 211

5329

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clagettsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clagettsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <b>James A. Moxley</b>				4. DATE OF DEATH Month Day Year <b>May 20 1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 1 1876</b>		9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Washington Moxley</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Baker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>##</b>		16. SOCIAL SECURITY NO. <b>#####</b>		17. INFORMANT <b>James E. Moxley</b>		Address <b>Mt. Airy Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adams-Stokes Syndrome</b> <b>420.0</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO <b>Hypertension</b> (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b> <b>10 years or more</b> <b>20 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized osteoarthritis, Mild diabetes mellitus, Old cerebro-vascular accident, Benign prostatic hypertrophy</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Feb.</b> , 19 <b>55</b> , to <b>May 20</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>May 20</b> , 19 <b>56</b> , and that death occurred at <b>8:35 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Gilcin F. Meadors, Jr. M.D. Boyer Clinic, Damascus, Md. 5/22/56</b>							
ACTUAL SIGNATURE <b>Gilcin F. Meadors, Jr.</b> M.D. <b>Boyer Clinic, Damascus, Md. 5/22/56</b>							
PHYSICIAN'S NAME (Type) <b>Gilcin F. Meadors, Jr. M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 23</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Montgomery Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Clagettsville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ray W. Barber</b>				24a. REC'D BY REGISTRAR <b>May 23, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Della W. Burdette</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

52

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Arthur Schopenhauer

BUREAU V.

MAY 25 1956

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5243

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tokoma Pk.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tokoma Pk.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash Sanitarium</u>				d. STREET ADDRESS <u>8502 Greenwood Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Eugene Duke Mullin</u>				4. DATE OF DEATH Month <u>5</u> Day <u>31</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/28/03</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>31</u> Hours <u>1</u> Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec. Dept of ag.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Secretary New York</u>			
11. BIRTHPLACE (State or foreign country) <u>Amer.</u>				12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>			
13. FATHER'S NAME <u>Eugene W. Mullin</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Duke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Wife</u>			
17. INFORMANT <u>8502 Greenwood Ave</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>162X Bronchial Obstruction</u> DUE TO <u>Primary Carcinoma of Bronchus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 year.</u> DUE TO (c) <u>1 year.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 year.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 6</u> , 19 <u>56</u> , to <u>May 31</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 31</u> , 19 <u>56</u> , and that death occurred at <u>1055 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilford D. Meyers</u> M.D. <u>8323 Radcliff Dr</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>5-31-56</u>			
PHYSICIAN'S NAME (Type) <u>WILFORD D. MEYERS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>June 4-1956</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Winington National</u>				22d. LOCATION (City, town, or county) (State) <u>Winington Virginia</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u> ADDRESS <u>254 Carroll St</u>				24. REC'D BY REGISTRAR <u>DATE 2 1956</u>			
25. REGISTRAR'S SIGNATURE <u>J. Wilson Hall</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 after death. Page 2 after death. Page 3 after death. The law requires that the death certificate be executed within 24 hours after death. Page 1 after death. Page 2 after death. Page 3 after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be verified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

BUREAU V. 2

UN 4 1956

RECEIVED

WILLIAM J. MEYER

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5244

## CERTIFICATE OF DEATH

05318

Reg. Dist. No. 223

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Montgomery</b>	<b>MARYLAND</b>	STATE <b>D.C.</b>	COUNTY <b>47X-3</b>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Takoma Park</b>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Washington</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Eventide Rest Home</b>		STREET ADDRESS (If rural give location) <b>4825 48th Street, N.W.</b>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<b>KATHRYN MURRAY</b>		<b>MAY 17 1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <b>3-18-85</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own business</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
13. FATHER'S NAME <b>William Reynolds</b>		14. MOTHER'S MAIDEN NAME <b>Susan Roach</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <b>Coronary thrombosis</b>			<b>few minutes</b>
ANTECEDENT CAUSE(S) DUE TO (B) <b>Generalized arteriosclerosis</b>			<b>years</b>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>May 20, 1956</b> to <b>May 6, 1956</b> , that I last saw the deceased alive on <b>May 6, 1956</b> , and that death occurred at <b>4:57 P.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>C.P. Ryland</b>		DATE SIGNED <b>5-7-56</b>	
23. BURIAL, CREMATION, REMOVAL (Specify)		24. REC'D BY REGISTRAR	
DATE THEREOF <b>5/9/56</b>		REGISTRAR'S SIGNATURE <b>J. H. Hines</b>	
NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		LOCATION (City, town, or county) (State) <b>Pr. Geo. Co., Maryland</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		ADDRESS <b>2901 14th St. N.W. Washington, D.C.</b>	

**BUREAU V. 5**

MAY 10 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5245

## CERTIFICATE OF DEATH

05319  
223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1956</u>		5. SEX <u>Fe</u> 6. COLOR OR RACE <u>cauc</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <u>5-22-1898</u> 9. AGE (In years last birthday) <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Geary Spicher</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Rolley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hosp Records</u>	
17. INFORMANT <u>Hosp Records</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Rhabdomyosarcoma</u> DUE TO <u>197X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>18 mo</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-15-1956</u> to <u>5-31-1956</u> , that I last saw the deceased alive on <u>5-30-1956</u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul V. Starr</u> M.D.		ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u> DATE SIGNED <u>5-31-56</u>	
PHYSICIAN'S NAME (Type) <u>PAUL V. STARR</u>		<u>7600 Carroll Ave.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 2, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Arthur Williams</u>		ADDRESS <u>254 Carroll St. NW</u>	
24a. REC'D BY REGISTRAR <u>6/1/56</u>		24b. REGISTRAR'S SIGNATURE <u>William North</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18 BALTIMORE—BALTIMORE DEPARTMENT OF HEALTH



MEDICAL CERTIFICATION

VS. A15ME(5)  
SM 9/SS

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 15 1956

RECEIVED

OCT 1 1956

OFFICE OF THE MEDICAL EXAMINER

MEDICAL CERTIFICATION

VS. A15ME(5)  
5M 9/55

BUREAU V. 1

MAY 25 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5331

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05322

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>			c. LENGTH OF STAY IN 1b <b>4 years</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>00 1564 East-West Highway</b>				d. STREET ADDRESS <b>1564 East-West Highway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDWARD ALOYSIUS O'NEILL</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>5</b> Year <b>19 56</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 24, 1900</b>		9. AGE (In years last birthday) <b>56 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Co-ordinator of Service--Shoreham Hotel</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brooklyn, New York</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas A. O'Neill</b>			14. MOTHER'S MAIDEN NAME <b>Anna McGrath</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW #2</b>		16. SOCIAL SECURITY NO. <b>577-05-4414</b>		17. INFORMANT <b>Edward S. O'Neill, 1564 East-West Hgwy., SS., Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Reptile bites</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>		DATE SIGNED <b>5-5-56</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 8, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery, Arlington County, Va.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey</b>				ADDRESS <b>Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR <b>5/8/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>James P. Pater</b>			

TO DEED MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, date, time, place, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

MAY 10 1956

RECEIVED

5332

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

05323

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>21 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				e. STREET ADDRESS <b>914 2nd Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Janet</b> Middle <b>Marie</b> Last <b>PALMER</b>				4. DATE OF DEATH Month <b>May</b> Day <b>11</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>22 July 1931</b>	
9. AGE (In years last birthday) yrs. <b>24</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Frank Gordon LAMBDIN</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. DOTY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>James Albert PALMER (Husband) (Same As #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>592x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchopneumonia</b> DUE TO (c) <b>Chronic Glomerulonephritis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>72 hours</b> <b>9 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>20 April 1956</b> , to <b>11 May 1956</b> , that I last saw the deceased alive on <b>11 May 1956</b> , and that death occurred at <b>12:05 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Willard P. Arentzen</b>				ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Willard P. ARENTZEN, CDR, MC, USN.</b>				DATE SIGNED <b>5-12-56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-14-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Southern Methodist Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Alexandria, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>CUNNINGHAM Funeral Home, Cameron &amp; Alfred Sts.</b>				24a. REC'D BY REGISTRAR <b>DATE 5-11-56</b>		24b. REGISTRAR'S SIGNATURE <b>Mary E. Parrelly</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 14 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

05324  
Reg. Dist. No. 216

5333

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>2 mo. 10 days</u>		d. STREET ADDRESS <u>6413 Winnipeg Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lucille Ann</u> First Middle Last		4. DATE OF DEATH <u>May 19</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-23-1918</u>
9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>9 26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Merrill, Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin Severt</u>		14. MOTHER'S MAIDEN NAME <u>Randina Thronsen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Sister Mrs. Edward Cain</u> Address <u>5012 N. 64th St. Milwaukee, Wis.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Liver</u> 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adeno carcinoma of Colon</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 Mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 29</u> , 19 <u>55</u> , to <u>date</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 19</u> , 19 <u>56</u> , and that death occurred at <u>7:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John G. Ball</u>		ADDRESS (Street, city or town, state) <u>Bethesda, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>John G. Ball</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		22b. DATE THEREOF <u>5-21-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wisconsin Memorial Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Milwaukee, Wisconsin</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 5-22-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05325

5334

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>(Dist. of Columbia)</b> b. COUNTY <b>P.D.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>18 Days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>5749 Southern St., S.E.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Hugh</b> Middle <b>Garmany</b> Last <b>PEARSON</b>		4. DATE OF DEATH Month <b>May</b> Day <b>11</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>13 Feb. 1898</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Draftsman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>	
11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Hugh PEARSON</b>		14. MOTHER'S MAIDEN NAME <b>Mary DOUGLAS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>(Wife) Mrs. Verna C. PEARSON (Same As #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic coma</b> DUE TO <b>5810</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cirrhosis of the liver</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Esophageal varices.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>23 April</b> , 19 <b>56</b> , to <b>11 May</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>11 May</b> , 19 <b>56</b> , and that death occurred at <b>9:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>William I. Freud</b> M.D. <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b> <b>5/12/56</b>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>William I. Freud, LT, MC, USN</b> <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>5-15-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wm Lee Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>4th &amp; Mass. Ave., N.W. Wash. D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LEE Funeral Home, 4th &amp; Mass Ave., N.W. Wash, D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE 5-11-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary E. Cassel</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 14 1956

RECEIVED

5335

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>5034 41st Street, N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Annie Margaret Perry</u>		4. DATE OF DEATH <u>May 15</u> 19 <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1896</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR <u>5</u> Months <u>9</u> Days <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Dist. of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George M. Stadtler</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Kirby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Sister Marie Pyles, 5000 Saratoga Ave Bethesda</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalomalacia, left cerebrum</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>thrombosis left internal carotid</u> DUE TO (c) <u>5th day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 3, 1956</u> , to <u>May 15, 1956</u> , that I last saw the deceased alive on <u>May 14, 1956</u> , and that death occurred at <u>8:25 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Washington, D.C.</u> DATE SIGNED <u>5/15/56</u>			
ACTUAL SIGNATURE <u>Sidney C. Cousins</u> M.D. <u>3921 Ingomar St. N.W. Wash. D.C.</u>		PHYSICIAN'S NAME (Type) <u>SIDNEY C. COUSINS</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-18-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>5-16-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

MEDICAL CERTIFICATION

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1910</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Teacher</i>	
7. DATE OF DEATH <i>May 10 1950</i>		8. TIME OF DEATH <i>10:30 AM</i>		9. PLACE OF DEATH <i>Home</i>		10. CAUSE OF DEATH <i>Heart Disease</i>		11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF WITNESSES <i>Mr. &amp; Mrs. J. Doe</i>		15. SIGNATURE OF CLERK <i>John Doe</i>		16. SIGNATURE OF REGISTRAR <i>John Doe</i>		17. SIGNATURE OF JUDGE <i>John Doe</i>		18. SIGNATURE OF SHERIFF <i>John Doe</i>	
19. SIGNATURE OF CORONER <i>John Doe</i>		20. SIGNATURE OF DISTRICT ATTORNEY <i>John Doe</i>		21. SIGNATURE OF COUNTY CLERK <i>John Doe</i>		22. SIGNATURE OF COUNTY SHERIFF <i>John Doe</i>		23. SIGNATURE OF COUNTY JUDGE <i>John Doe</i>		24. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	

RECEIVED  
MAY 21 1950  
BUREAU V. S.

## CERTIFICATE OF DEATH

05327

Reg. Dist. No. 217

5336

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Va</u> b. COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Northbrook Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Philomena's Rest Home</u>		d. STREET ADDRESS <u>2007-S. Joyce St.</u>	
3. NAME OF DECEASED (Type or print) <u>Sophie</u> First <u>F.</u> Middle <u>PRICE</u> Last		4. DATE OF DEATH <u>May 23</u> 19 <u>56</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 2, 1894</u> 61 yrs.
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Va</u>	
11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles A. Norton</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Albert J. Price</u> Address <u>2007-Joyce St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Diabetes Mellitus, Fracture right femur (ununited) old injury</u> 260 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> Years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 14</u> , 19 <u>56</u> , to <u>May 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 20</u> , 19 <u>56</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry J. Kicherer</u> M.D. <u>2516-Pa. Ave. SE</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>HARRY J. KICHERER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 26, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Jones Sons Co.</u> ADDRESS <u>300-4 St. N.E.</u>		24a. REC'D BY REGISTRAR <u>DATE 5-26-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bernard B. Fowler</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V.

1956 JUN 1

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5337 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05328

Reg. Dist. No. 216

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10543 St Paul st</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> d. STREET ADDRESS <u>10543 St Paul st</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Dorothy</u> Middle <u>E</u> Last <u>Probey</u>		<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>23</u> Year <u>1956</u>		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>1-10-1911</u> <b>9. AGE</b> (In years last birthday) <u>45</u> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Nurse</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Nurse</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>P.H. Service</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Canada</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>? Mygrant</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Chloe ?</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <u>Korean</u> <b>16. SOCIAL SECURITY NO.</b> <u>No</u> <b>17. INFORMANT</b> <u>J. F. Probey (husband)</u> Address <u>Dave as item 2</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> o. m. p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Brosch</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Brosch</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <u>5-23-56</u>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>5-26-56</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn</u> <b>22d. LOCATION</b> (City, town, or county) (State) <u>Montgomery Maryland</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u> <b>ADDRESS</b> <u>Bethesda, Md.</u> <b>24a. REC'D BY REGISTRAR</b> <u>5-25-56</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Bennie M. Thompson</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any certificate is necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
A FORM FOR THE EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 29 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film GL 88-6-16-56 et

## CERTIFICATE OF DEATH

05329

Reg. Dist. No. 216

5338

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>4515 Avondale St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CLINTON M. QUIGLEY</b> First Middle Last				4. DATE OF DEATH <b>May 30, 1956</b> Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 14, 1901</b> 9. AGE (In years last birthday) <b>44 51</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fighting Fires</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James C. Quigley</b>				14. MOTHER'S MAIDEN NAME <b>Mabel Hoffmaster</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Wife-Doris C. Quigley</b>		Address <b>Bethesda, Md. 4515 Avondale St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma</b> <b>153x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>carcinoma of splenic flexure of colon</b> DUE TO (c) <b>17 yrs.</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>12/2, 1954</b> to <b>5/30, 1956</b> , that I last saw the deceased alive on <b>5/28, 1956</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6306 Wisconsin Ave.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>D. L. Marks</b>				M.D. <b>I. L. MARKS</b>			
PHYSICIAN'S NAME (Type) <b>I. L. MARKS</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-2-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>		22d. LOCATION (City, town, or county) (State) <b>Gaithersburg Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>6-4-56</b> 24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

TO HOST OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V. S.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05330

Reg. Dist. No. 218

5339

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. LENGTH OF STAY IN lb <u>14 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D. #3</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Willie</u> First <u>Ridgley</u> Middle <u>Ridgley</u> Last				4. DATE OF DEATH <u>May</u> Month <u>22</u> Day <u>1956</u> Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>ore</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-14-1895</u>	
9. AGE (In years last birthday) <u>61</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Ridgley</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Beel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Christine Ridgley (wife)</u> Address <u>Same as dec'd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION <u>Burial</u>		22b. DATE THEREOF <u>5/26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant View</u>		22d. LOCATION (City, town, or county) <u>Quince Orchard, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Smucker</u> ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u>Alfreda Cook</u> DATE _____		24b. REGISTRAR'S SIGNATURE _____	

MEDICAL CERTIFICATION

TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any part of this certificate is necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-BALDWIN 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 7 1956

RECEIVED

5340  
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <b>MARYLAND</b> <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Hall Rest Home</b>				d. STREET ADDRESS <b>7001 Hillcrest Place</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>ALBERT C. ROOT</b>				4. DATE OF DEATH <b>May 8, 1956</b>			
5. SEX <b>Male</b>				6. COLOR OR RACE <b>White</b>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>7/19/65</b>			
9. AGE (In years last birthday) <b>90</b>				10. IF UNDER 1 YEAR <b>9</b> Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.-Mail Service</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>			
11. BIRTHPLACE (State or foreign country) <b>Kansas</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Frank A. Root</b>				14. MOTHER'S MAIDEN NAME <b>Emma Clark</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Irving C. Root-Item # 2</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Block, complete, acute</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalised Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b> <b>10 yrs +</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic prostatism with obstruction</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July</b> , 19 <b>55</b> , to <b>May 8</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>May 8</b> , 19 <b>56</b> , and that death occurred at <b>9:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3921 Ingoman St Wash DC</b> DATE SIGNED <b>5-8-56</b>							
ACTUAL SIGNATURE <b>Stewart Clapp</b>				M.D. <b>3921 Ingoman St Wash DC</b>			
PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>5-9-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>5-10-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 14 1956

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5341

## CERTIFICATE OF DEATH

05332

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>47X-3</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>139 das.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, NIH</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Felden</u> Last <u>Roth</u>		4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1956</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 May 1901</u>	
9. AGE (In years last birthday) <u>55 yrs.</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Theatre Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Motion Picture</u>		
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Morris Roth</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Felden</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not Avail.</u>		
17. INFORMANT <u>The Medical Record, Clinical Center, NIH</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive nontraumatic fibrous pneumonia</u> <u>197X</u> DUE TO <u>Pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Moderate aspiration of food + blood clot</u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fatty melanosis liver</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>December 14, 1955</u> , to <u>May 1, 1956</u> , that I last saw the deceased alive on <u>May 1, 1956</u> , and that death occurred at <u>10<sup>50</sup> P.M.</u> from the causes and on the date stated above.				
ACTUAL SIGNATURE <u>William M. Kramer</u> M.D.		ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>		
DATE SIGNED <u>5/2/56</u>		DATE SIGNED		
PHYSICIAN'S NAME (Type) <u>William M. Kramer, M. D.</u>		DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/4/56</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Hebrew</u>		22d. LOCATION (City, town, or county) (State) <u>Congress Heights, D. C.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danyanaky + Son D.W., Wash, D.C.</u>		24a. REC'D BY REGISTRAR <u>5-9-56</u>		
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		DATE SIGNED		



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
JAMES H. HARRIS		65		M		W		1888		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		1953		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1910		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		1953		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		1953		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		SUICIDE		1953		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		1953		BALTIMORE		BALTIMORE		BALTIMORE		1953		BALTIMORE		BALTIMORE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
1953		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		1953		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		1953		BALTIMORE		BALTIMORE		BALTIMORE	

BUREAU V. S.

MAY 11 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05333**

5342

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4607 Maple Avenue</b>				d. STREET ADDRESS <b>4607 Maple Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>A.</b> Last <b>ROYAL</b>		4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>19 56</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 18, 1885</b>		9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months <b>19</b> Days <b>3</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Johnson Co. N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>William Royal</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-05-7656</b>		17. INFORMANT Address <b>Mrs. Viola Royal-Same Item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Frank J. Broschart, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-23-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 5-24-56</b>		24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	

MEDICAL CERTIFICATION

TO DECEASED: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any certificate is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Pages 4 and 5 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
MAY 25 1956

MAY 25 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5343

## CERTIFICATE OF DEATH

05334

Reg. Dist. No. 26

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>33 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>922 Rockville Pike</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Glenn</b> Middle <b>Christian</b> Last <b>Sager</b>				4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 21, 1916</b>	
9. AGE (In years last birthday) <b>39</b> yrs.		IF UNDER 1 YEAR Months <b>39</b> Days <b>16</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Months <b>39</b> Days <b>16</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>	
13. FATHER'S NAME <b>Paul Christian Sager</b>				14. MOTHER'S MAIDEN NAME <b>Lydia Marie McFall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes - Active Serviceman</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pulmonary congestion and hemorrhage</b> DUE TO (b) <b>acute leukemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>liver abscess; gastrointestinal hemorrhage</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>liver abscess; gastrointestinal hemorrhage</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>None</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I and Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>April 13, 1956</b> , to <b>May 16, 1956</b> , that I last saw the deceased alive on <b>May 16, 1956</b> , and that death occurred at <b>10:23 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Mehran Goulian</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>5/17/56</b>			
PHYSICIAN'S NAME (Type) <b>Mehran Goulian, M. D.</b>				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-17-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WAGNER S.D. DAKOTA</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Michael J. Rinaldi</b>				ADDRESS <b>816-H St. NW</b>		24a. REC'D BY REGISTRAR <b>DATE 5-17-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John J. Jones		Male		45		1915		Maryland		Baltimore		Heart Disease		May 15, 1956		Home		10:00 AM		J. J. Jones		J. J. Jones	
Occupation		Married		Single		Married		Single		Single		Single		Single		Single		Single		Single		Single	
Education		High School		High School		High School		High School		High School		High School		High School		High School		High School		High School		High School	
Religion		Catholic		Catholic		Catholic		Catholic		Catholic		Catholic		Catholic		Catholic		Catholic		Catholic		Catholic	
Service		U.S. Army		U.S. Army		U.S. Army		U.S. Army		U.S. Army		U.S. Army		U.S. Army		U.S. Army		U.S. Army		U.S. Army		U.S. Army	
Remarks		Remarks		Remarks		Remarks		Remarks		Remarks		Remarks		Remarks		Remarks		Remarks		Remarks		Remarks	

BUREAU V. 5

MAY 21 1956

RECEIVED

21-1-6  
816-4111



5246

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>19th and Pk. Md</u>		c. LENGTH OF STAY IN 1b <u>8 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna Scharr</u>		4. DATE OF DEATH Month Day Year <u>5-13-1956</u>			
5. SEX <u>Female</u> 6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-17-89</u>	9. AGE (In years last birthday) <u>66</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Russia</u>		
13. FATHER'S NAME <u>Samuel Shapiro</u>		14. MOTHER'S MAIDEN NAME <u>Hattie (un known)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr Charles Scharr Same - Husband</u>			
17. INFORMANT <u>Mr Charles Scharr</u> Address <u>Same - Husband</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Coronary atherosclerosis</u> DUE TO (b) <u>Coronary atherosclerosis</u> (c) <u>Diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>10-15, 1955</u> , to <u>5-13, 1956</u> , that I last saw the deceased alive on <u>5-13, 1956</u> , and that death occurred at <u>5:10 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Josm Heiger</u> M.D. <u>931 Bethesda Drive</u>		DATE SIGNED <u>5/16/56</u>			
PHYSICIAN'S NAME (Type) <u>Silver Spring, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/15/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MONTEFIORE CEM</u>	22d. LOCATION (City, town, or county) (State) <u>QUEENS, N.Y.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Funeral Home</u> ADDRESS <u>4217-9th av</u>		24. REC'D BY REGISTRAR <u>DATE 5/16/56</u>			
24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dadd</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 17 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1c, & 2, Film G199 June 21, 1956

## CERTIFICATE OF DEATH

Reg. Dist. No. **214**

05336

**5344**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>47X-3</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural KENSINGTON</b>			c. LENGTH OF STAY IN 1b <b>2 1/2 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1618 Hobart St. N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>EMMA</b> Middle <b>A.</b> Last <b>SCHNEIDER</b>				<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>31</b> Year <b>19 56</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>April 1, 1861</b>	
<b>9. AGE</b> (In years last birthday) <b>95</b> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>At Home</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Maryland</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>							
<b>13. FATHER'S NAME</b> <b>Edwin F. Brooks</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Emma Cooper</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>Louis B. Schneider, Silver Spring, Md</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO <b>Arterio-sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arterio-sclerosis Heart Disease</b>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <b>3/1/56</b> , 19____, <b>to</b> <b>5/31/56</b> , 19____, <b>that I last saw the deceased alive on</b> <b>5/30/56</b> , 19____, <b>and that death occurred at</b> <b>7:10 A.M.</b> , from the causes and on the date stated above. <b>ADDRESS</b> (Street, city or town, state) <b>DATE SIGNED</b>							
<b>ACTUAL SIGNATURE</b> <b>James A. O'Keefe</b> M.D.				<b>PHYSICIAN'S NAME (Type)</b> <b>James A. O'Keefe M.D.</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>6/2/56</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Rock Creek Cemetery</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Washington D C</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Joseph Barker</b> ADDRESS <b>756 Penna Ave N W</b>				<b>24a. REC'D BY REGISTRAR</b> <b>6/2/56</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Francis Patten</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME MONTGOMERY		DATE OF BIRTH April 1, 1901	
SEX Male		RACE White	
PLACE OF BIRTH At Home		CITY OF BIRTH Baltimore, Maryland	
OCCUPATION Louis E. Schmeider, Silver Business, Md		EDUCATION None	
CAUSE OF DEATH Heart Failure		MANNER OF DEATH Natural	
DATE OF DEATH June 9, 1956		PLACE OF DEATH Rock Creek Cemetery	
SIGNATURE OF DECEASED None		SIGNATURE OF WITNESSES None	
SIGNATURE OF PHYSICIAN None		SIGNATURE OF CORONER None	
SIGNATURE OF REGISTRAR None		SIGNATURE OF CLERK None	

RECEIVED  
JUN 9 1956  
BUREAU A. 2

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5247 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05337  
7/13

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>471-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.C.A.</u>				c. LENGTH OF STAY IN 1b <u>District of Columbia</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>				d. STREET ADDRESS <u>249 Hawaii Ave, N.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>Walter</u> Last <u>Scilemy</u>				4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-29-30</u>	
9. AGE (In years last birthday) <u>25</u> yrs.		IF UNDER 1 YEAR Months <u>25</u> Days <u>25</u> Hours <u>25</u> Min. <u>25</u>		IF UNDER 24 HRS. Months <u>25</u> Days <u>25</u> Hours <u>25</u> Min. <u>25</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Johnstown Pa.</u>	
13. FATHER'S NAME <u>Peter Scilemy</u>				14. MOTHER'S MAIDEN NAME <u>Mary Gluchman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Army</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mrs. Margaret Scilemy - Wife</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause for line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial failure</u>            DUE TO <u>273x</u>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute respiratory effort (Trumpet Player)</u>            DUE TO <u>Myocardial Ischemia</u>            (c) <u>—</u></p> </div> <div style="width: 45%;"> <p>INTERVAL BETWEEN ONSET AND DEATH  <u>5 minutes</u>  <u>30 minutes</u></p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Status thymicolymphaticus</u></p>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Shipment</u>		22b. DATE THEREOF <u>May 14, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Church Cemetery, Johnstown, Penna.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>5/16/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. Nelson Addy</u>			

MEDICAL CERTIFICATION

2

2

TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any necessary, please enclose a copy of this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MISSOURI STATE DEPARTMENT OF HEALTH—BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document.]*

BUREAU V. 1

MAY 16 1956

RECEIVED

5345

# CERTIFICATE OF DEATH

05338

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>California</b> b. COUNTY <b>43X-3</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				d. STREET ADDRESS <b>835 Freeman Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Lois</b> Middle <b>Ann</b> Last <b>SCRANTON</b>				4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>30 January 1956</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		9. AGE (In years lost birthday) yrs. <b>3</b> Months <b>8</b> Days <b>8</b> Hours <b>3</b> Min.	
13. FATHER'S NAME <b>Buel SCRANTON</b>				14. MOTHER'S MAIDEN NAME <b>Isabelle Chaput</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(Father) Buel SCRANTON (Same as #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Pulmonary Infarction</b> <b>916.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>3° burns 40% body, Rt. leg amputation</b> (c) <b>due to gangrene; thrombophlebitis, legs</b>						INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b> <b>18 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>The infant was placed by the mother on a pillow, on or near a stove. The burner was accidentally turned on by another child of the household.</b>			
20c. TIME OF INJURY Hour <b>1640</b> o. n. <b>Apr. 20</b> p. m. <b>1956</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
				20f. (City or town) <b>Qtrs. Fort Campbell, Kentucky</b>		(County) (State)	
21. I certify that I attended the deceased from <b>2 May</b> , 19 <b>56</b> , to <b>8 May</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>8 May</b> , 19 <b>56</b> , and that death occurred at <b>7:06 P.</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Burt C. Johnson</b>				ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Burt C. Johnson, LCDR, MC, USN</b>				DATE SIGNED <b>9 May 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-9-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>5-8-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary E. Parrelly</b>			

MEDICAL CERTIFICATION

88

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

<p>1. NAME OF DECEASED                  (Last, first, middle initial)                  _____</p>		<p>2. SEX                  (M or F)                  _____</p>	
<p>3. AGE                  (In years, months, and days)                  _____</p>		<p>4. DATE OF BIRTH                  (Month, day, year)                  _____</p>	
<p>5. PLACE OF BIRTH                  (City, county, and state)                  _____</p>		<p>6. OCCUPATION                  _____</p>	
<p>7. MARITAL STATUS                  (Single, Married, Widowed, Divorced)                  _____</p>		<p>8. DATE OF DEATH                  (Month, day, year)                  _____</p>	
<p>9. CAUSE OF DEATH                  (Immediate cause)                  _____</p>		<p>10. UNDERLYING CAUSE                  (Underlying cause)                  _____</p>	
<p>11. PLACE OF DEATH                  (City, county, and state)                  _____</p>		<p>12. SIGNATURE OF PHYSICIAN                  _____</p>	
<p>13. SIGNATURE OF REGISTRAR                  _____</p>		<p>14. SIGNATURE OF WITNESS                  _____</p>	

BUREAU V. S.

MAY 10 1956

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**Item 3, Film G196 5-10-56 et**  
**5346 CERTIFICATE OF DEATH**

05339

Reg. Dist. No. 215

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float:right">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN TB <u>3 hr. 15 min.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, NMMC, Bethesda, Md.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> <span style="float:right">b. COUNTY <u>47X-3</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1117 Michigan Ave., N.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>Anthony</u> Last <u>SEITZ</u>				<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>6</u> Year <u>1956</u>					
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>March 21, 1986</u>		<b>9. AGE</b> (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Guard</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Gov't</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>New York</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>US</u>	
<b>13. FATHER'S NAME</b> <u>Unknown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW-1</u>				<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>		<b>17. INFORMANT</b> <u>Mrs. Alida M. SEITZ, Wife, Same As #2</u> Address _____			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO (b) <u>Myocardial failure due to Myocardial Infarct</u> DUE TO (c) <u>Coronary Thromboses, at coronary artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>1.5 hr</u> <u>6 hrs</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. s. _____ p. m. _____ 19 _____				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21. I certify that I attended the deceased from</b> <u>5 May</u> , 19 <u>56</u> , to <u>6 May</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6 May</u> , 19 <u>56</u> , and that death occurred at <u>12:45 A.M.</u> , from the causes and on the date stated above.									
<b>ACTUAL SIGNATURE</b> <u>Willard P. Arentzen</u> M.D.				<b>ADDRESS</b> (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u>				<b>DATE SIGNED</b> <u>7 May 1956</u>	
<b>PHYSICIAN'S NAME (Type)</b> <u>Willard P. Arentzen, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.</u>									
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>5-9-56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) <u>Arlington</u> (State) <u>Virginia</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. J. Nalley</u> ADDRESS <u>Washington, D.C.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>DATE 5-7-56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Mary E. Cassel</u>			
<b>Nalley's Funeral Home, 3200 R.I. Ave, Mt. Ranier</b>									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(一)

MAY 9 1956

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5347

CERTIFICATE OF DEATH

05340

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>474.3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Maryland</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Milton</u> Last <u>SELLMAN</u>				4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>20 May 1897</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME <u>Frank SELLMAN (Deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Lizzie WINSTON (Deceased)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>Yes</u> <u>WW-1</u>				16. SOCIAL SECURITY NO. <u>  </u>			
17. INFORMANT <u>(Sister) Helen T. FORD (Sameas #2)</u>				Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningitis</u> <u>340.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumococcal pneumonia</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Urthral stricture</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>3 May</u> <u>1956</u> , to <u>5 May</u> <u>1956</u> , that I last saw the deceased alive on <u>5 May</u> <u>1956</u> , and that death occurred at <u>11:10A M.</u> from the causes and on the date stated above. <u>Harold I. Passes, M.D.</u> ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>5-5-56</u>							
ACTUAL SIGNATURE <u>Harold I. PASSES, LT, MC, USN</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>							
PHYSICIAN'S NAME (Type) <u>Harold I. PASSES, LT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-8-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Morrow &amp; Woodford Funeral Home, 1622 11th St.,</u>				24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Garselly</u>	

RECEIVED

5348

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Rural</b>		c. LENGTH OF STAY IN 1b <b>19 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		e. STREET ADDRESS <b>1004 10th Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>Maurice</b> Last <b>SHEAF</b>		4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-21-07</b>
9. AGE (In years last birthday) <b>48 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mariner Retired</b>	11. BIRTHPLACE (State or foreign country) <b>New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>William SHEAF</b>	
14. MOTHER'S MAIDEN NAME <b>Louise TURNER</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Wife Mrs. Hazel G. SHEAF</b> Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, esophagus</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8 May</b> , 19 <b>56</b> , to <b>27 May</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>27 May</b> , 19 <b>56</b> , and that death occurred at <b>1:20 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>M. L. Gerber</b>		ADDRESS (Street, city or town, state) <b>USNH, NNMC, Bethesda, Maryland</b> DATE SIGNED <b>5-28-56</b>	
PHYSICIAN'S NAME (Type) <b>M. L. GERBER, CAPT, MC, USN</b>		<b>USNH, NNMC, Bethesda, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-31-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Demaine Funeral Home, 524 Mt. Vernon Blvd.</b>		24a. REC'D BY REGISTRAR <b>DATE 5-28-56</b>	24b. REGISTRAR'S SIGNATURE <b>Mary E. Russell</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of this certificate may be filed with the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**BUREAU V. S.**

MAY 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5349

## CERTIFICATE OF DEATH

Reg. Dist. No.

05342  
216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> <b>47X-3</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>		d. STREET ADDRESS <b>1835 Newton Street, N. W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Elizabeth Victoria Snowden</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> , Year <b>56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 21, 1866</b>
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Teaching school</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Snowden</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Price</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation (bronchial obstruction)</b> <b>190X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Malignant melanoma</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 14, 1955</b> , to <b>May 10, 1956</b> , that I last saw the deceased alive on <b>May 10, 1956</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>May 10, 1956</b> ACTUAL SIGNATURE <b>Claude E. Forkner, Jr.</b> M.D. <b>The National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>Claude E. Forkner, Jr., M.D.</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/12/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24a. REC'D BY REGISTRAR DATE <b>5-12-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Bennie M. Thompson</b>			



CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		PLACE OF BIRTH	
MARRIAGE		OCCUPATION	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		PLACE	

BUREAU V. S.

MAY 15 1956

RECEIVED

## 5350 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: Mont. COUNTY 145-11 Colsonville Rd. Md. MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Montgomery CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Springs Md. 56	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Springs Md. 56		STREET ADDRESS (If rural, give location) 145-11 Colsonville Rd.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Maxvillea Tuning Home			
3. NAME OF DECEASED: (Type or Print) Mary A Stein		4. DATE (Month) (Day) (Year) OF DEATH: May 28 1956	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: 3/9/18-62
9. AGE last birthday: 94 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: Housewife	
11. BIRTHPLACE (State or foreign country): Wash. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: Christian Widmayer		14. MOTHER'S MAIDEN NAME: Katharine Betz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: Gertrude Wannon			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422.1 IMMEDIATE CAUSE (A) Congestive heart failure		20
ANTECEDENT CAUSE (B) Arteriosclerotic vas. disease		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
--	--	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from April 1, 1956, to May 28, 1956, that I last saw the deceased alive on May 28, 1956, and that death occurred at 7:45 P. M. from the causes and on the date stated above.

SIGNATURE	DATE SIGNED		
[Signature]	May 28 1956		
M. D. 401 Kennedy St NW Wash. D.C.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
5/31/56		Prospect Hill	Washington DC
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
5/29/56	Frances Potter	A. H. Hines Co.	2901-14th NW

MARGIN RESERVED FOR BINDING

VS. A15 — 10 45

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 4 1956

BUREAU V. S.

5351

CERTIFICATE OF DEATH

Reg. Dist. No. 05344 296

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>		d. STREET ADDRESS <b>3121 "P" Street, N. W.</b>	
3. NAME OF DECEASED (Type or print) First <b>Susan</b> Middle <b>Margretta</b> Last <b>Stroup</b>		4. DATE OF DEATH Month <b>May</b> Day <b>14</b> , Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 2, 1948</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		9b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	9. AGE (In years last birthday) <b>7</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Russell C. Stroup</b>		14. MOTHER'S MAIDEN NAME <b>Louise W. Wells</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2040 Shatro - Intestinal Hemorrhage</b> DUE TO (b) <b>Acute lymphocytic leukemia</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 27, 1956</b> to <b>May 14, 1956</b> , that I last saw the deceased alive on <b>May 14, 1956</b> , and that death occurred at <b>12:25P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>May 14, 1956</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland ACTUAL SIGNATURE <b>Martin Schick</b> M.D. PHYSICIAN'S NAME (Type) <b>Martin Schick, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>5/16/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Lynchburg, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co.</b>		24a. REC'D BY REGISTRAR DATE <b>5-16-56</b>	24b. REGISTRAR'S SIGNATURE <b>Beau M. Thompson</b>





24b. REGISTRAR'S SIGNATURE  
B. - 5. 12 - 5. 12

VS AIS (4)  
15M 9/55

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G197 5-22-56 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

115346223

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>474-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>41 days</u>		d. STREET ADDRESS <u>1803 Bittmore St. N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Emily</u> Last <u>Swift</u>		4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1878</u> <u>May 18, 1878</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min. <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Fox</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Sampson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Atherosclerotic heart disease</u> DUE TO (c) <u>generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Inanition secondary to Esophageal Hiatal Hernia with Obstruction</u>			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 15, 1956</u> to <u>May 15, 1956</u> , that I last saw the deceased alive on <u>May 15, 1956</u> , and that death occurred at <u>10 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Marvin L. Kolkin</u> M.D.		ADDRESS (Street, city or town, state) <u>2025 Eye Street, N.W., Wash 6, D.C.</u>	
DATE SIGNED <u>May 17 1956</u>			
PHYSICIAN'S NAME (Type) <u>Marvin L. Kolkin</u>		2025- Eye Street N.W., Washington, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAY 17, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glennwood Cem</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Kysanog</u>		ADDRESS <u>WASH. D.C.</u> DATE <u>MAY 17 1956</u>	
24. REGISTRAR'S SIGNATURE <u>John D. Bell</u>			

RECEIVED  
MAY 18 1956  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5249

## CERTIFICATE OF DEATH

05347

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Edgar</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-2-13</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate Penna.</u>			
11. BIRTHPLACE (State or foreign country) <u>America</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>James L. Taylor</u>				14. MOTHER'S MAIDEN NAME <u>AS ABOVE MINERVA HEIL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>AS ABOVE</u>			
17. INFORMANT <u>Patent - Same as listed</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> 541.0 DUE TO <u>Bleeding Duodenal Ulcer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Passive Malignancy</u> (c) <u>Passive Malignancy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 mos</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 56</u> to <u>Apr 10, 1956</u> , that I last saw the deceased alive on <u>May 10, 1956</u> , and that death occurred at <u>11:55 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Raymond Q. West</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 14, 1956</u>		<u>Greenwood Cem.</u>		<u>Laurel, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.P. Humphrey</u>				ADDRESS <u>7557 White Ave</u>			
24. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE <u>J. Wilson Reed</u>			
DATE <u>5/11/56</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1955

<p>1. NAME OF DECEASED                  [Faint text]</p>		<p>2. SEX                  [Faint text]</p>	
<p>3. AGE                  [Faint text]</p>		<p>4. RACE                  [Faint text]</p>	
<p>5. DATE OF BIRTH                  [Faint text]</p>		<p>6. PLACE OF BIRTH                  [Faint text]</p>	
<p>7. DATE OF DEATH                  [Faint text]</p>		<p>8. PLACE OF DEATH                  [Faint text]</p>	
<p>9. CAUSE OF DEATH                  [Faint text]</p>		<p>10. MANNER OF DEATH                  [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN                  [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR                  [Faint text]</p>	
<p>13. SIGNATURE OF WITNESS                  [Faint text]</p>		<p>14. SIGNATURE OF DECEASED                  [Faint text]</p>	

BUREAU V. S.

MAY 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5353

### CERTIFICATE OF DEATH

Reg. Dist. No. **214**

053484

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Maryland</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Independence</b>		54X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>		d. STREET ADDRESS <b>none</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Myrtle</b> Middle <b>Ethel</b> Last <b>Taylor</b>		4. DATE OF DEATH Month <b>May</b> Day <b>31</b> , Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 14, 1887</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John A. Pierson</b>		14. MOTHER'S MAIDEN NAME <b>Frances Simmons</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bleeding esophageal varices</b> DUE TO (c) <b>Cirrhosis - Diabetes mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial infarction - Coronary heart disease</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Days</b> <b>Years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 25, 1956</b> , to <b>May 31, 1956</b> , that I last saw the deceased alive on <b>May 31, 1956</b> , and that death occurred at <b>8:50 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Daniel D. Federman</b>		M.D. <b>The Clinical Center</b> <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Daniel D. Federman, M. D.</b>		DATE SIGNED <b>6/1/56</b>	
22a. BURIAL, CREMATION, RECOVERY (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/1/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>W. W. Chambers Co 1400 Chapin St</b>		22d. LOCATION (City, town, or county) (State) <b>Independence Kansas</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co</b>		24a. REC'D BY REGISTRAR <b>6/5/56</b>	
ADDRESS <b>1400 Chapin St</b>		24b. REGISTRAR'S SIGNATURE <b>Frances Potter</b>	

CERTIFICATE OF DEATH

Reg. No. 100

DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
CAUSE OF DEATH		PERIOD OF ILLNESS	
MANNER OF DEATH		PLACE OF BIRTH	
DATE OF BIRTH		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		SINGLE	
MARRIED		WIDOWED	
DIVORCED		SEPARATED	
RECEIVED		DATE	
BUREAU V. S.		JUN 7 1956	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled out by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05349

5253

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			
c. LENGTH OF STAY IN 1b <b>One year</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>13019 Evanston St.</b>				d. STREET ADDRESS <b>13019 Evanston St.</b>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>NORA</b> Middle <b>R</b> Last <b>TETLOW</b>		4. DATE OF DEATH		Month <b>May</b> Day <b>8</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Jan 10-1882</b>		9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>3</b> Days <b>28</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>C.O. McIntosh</b>				14. MOTHER'S MAIDEN NAME <b>Maria Moulden</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>M. Hough Daughter Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) <b></b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>20 yrs -</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Oct 1956</b> to <b>8 May 1956</b> , that I last saw the deceased alive on <b>May 1956</b> , and that death occurred at <b>9:00 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W.S. Murphy</b>				M.D. <b>E.S. Hough</b> ADDRESS (Street, city or town, state) <b>Bethesda Md.</b> DATE SIGNED <b>5-11-56</b>			
PHYSICIAN'S NAME (Type) <b>W.S. Murphy</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-10-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>		22d. LOCATION (City, town, or county) (State) <b>Beallsville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda Md</b>		24a. REC'D BY REGISTRAR <b>DATE 5-11-56</b> 24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5354 CERTIFICATE OF DEATH

05350

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPRINGFIELD - BETHESDA</u>	
c. LENGTH OF STAY IN 1b <u>39 DAYS</u>		d. STREET ADDRESS <u>5407-CHRISTY DRIVE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROSMOR, 5721 GROSVENOR LANE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Josephine Teresa Wall</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>4</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 19, 1882</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>CANADA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>PETER FOSTER</u>		14. MOTHER'S MAIDEN NAME <u>BRIDGET SHREENAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>THOMAS H. WALL, JR.</u>		Address <u>5407 CHRISTY DRIVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of lung</u> DUE TO (c) <u>Generalized arteriosclerosis + myocardial degeneration</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>1 yrs</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. _____ m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>4/7</u> , 19 <u>56</u> , to <u>5/4</u> , 19 <u>56</u> that I last saw the deceased alive on <u>5/3</u> , 19 <u>56</u> , and that death occurred at <u>3:55 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>S. A. Thomas</u> M.D. <u>4301 48TH ST. NW., WASH. D.C.</u> PHYSICIAN'S NAME (Type) <u>S. A. Thomas</u> <u>4301 48TH ST. NW., WASH. D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAY 7, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BUFFALO, NEW YORK</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. DeVOL</u>		ADDRESS <u>2224-WIS. AVE. D.C.</u>	
24a. REC'D BY REGISTRAR <u>5-7-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death. The text is mirrored and appears to be bleed-through from the reverse side of the page.

BUREAU V. S.

MAY 9 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5355

## CERTIFICATE OF DEATH

Reg. Dist. No. 05351/7

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney Gaithersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montg. Co. Gaithersburg</u>		e. STREET ADDRESS <u>330 E. Diamond Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Mary E. Walton</u>		4. DATE OF DEATH <u>May 31</u> 19 <u>56</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 12, 1876</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 24 HRS. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm Walton</u>		14. MOTHER'S MAIDEN NAME <u>Jane Erwin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Joseph Walton-Item #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure.</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetic Coma</u> DUE TO (c) <u>Diabetic Mellitus</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 31</u> , 19 <u>56</u> , to <u>May 31</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 31</u> , 19 <u>56</u> , and that death occurred at <u>4:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Luciano L. Leal</u> M.D.		ADDRESS (Street, city or town, state) <u>108 N. Frederick Ave.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Luciano L. Leal</u>		<u>Gaithersburg Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6-4-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert F. Pumphrey</u>		ADDRESS <u>Bethesda, Md</u>	
24a. REC'D BY REGISTRAR <u>5-31-56</u>		24b. REGISTRAR'S SIGNATURE <u>Kertrude B. Lawler</u>	

CERTIFICATE OF DEATH

1955

737

*[Faint, mostly illegible text from the reverse side of the document, appearing as bleed-through. Some words like "MAY 1955" and "BALTIMORE" are visible.]*



BUREAU V. S.

JUN 5 1956

RECEIVED

*[Faint text at the bottom of the page, possibly a date or reference number.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 8, Film G197 5-14-56 et  
5356  
CERTIFICATE OF DEATH

05352211  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Woodfield</b>		c. LENGTH OF STAY IN 1b <b>15 Years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Woodfield</b>		d. STREET ADDRESS <b>R.F.D. I Gaithersburg Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. I Gaithersburg Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LILLIAN GRIFFITH WARFIELD</b>		4. DATE OF DEATH Month <b>May</b> Day <b>I</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1871 July, 2 1872</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles H. Griffith</b>		14. MOTHER'S MAIDEN NAME <b>Hester Dorsey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Miss. Mary C, Warfield, Gaithersburg, Md</b>	
17. INFORMANT <b>Miss. Mary C, Warfield, Gaithersburg, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic spastic colitis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b> <b>5 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 3</b> , 19 <b>56</b> , to <b>May 1</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>April 30</b> , 19 <b>56</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Damascus, Md.</b> DATE SIGNED <b>5/3/56</b> ACTUAL SIGNATURE <b>James P. Kerr</b> M.D. PHYSICIAN'S NAME (Type) <b>JAMES P. KERR M.D. Damascus Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 4 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Goshen Cemt.</b>		22d. LOCATION (City, town, or county) (State) <b>Laytonsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ray W. Barber</b>		ADDRESS <b>Laytonsville</b>	
24a. REC'D BY REGISTRAR DATE <b>May 5-56</b>		24b. REGISTRAR'S SIGNATURE <b>Wella W. Burdette</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial-transit permit. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/56

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film 198 6-8-56 et

5357

CERTIFICATE OF DEATH

05353

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac-Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac-Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD#2 Rockville</u>				d. STREET ADDRESS <u>RFD#2 Rockville</u>			
3. NAME OF DECEASED (Type or print) <u>LOUISE</u> First <u>L.</u> Middle <u>WATKINS</u> Last				4. DATE OF DEATH <u>May 29,</u> 19 <u>56</u> Month Day Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1879</u> <u>Feb. 29, 1956</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Robert Stone</u>			
14. MOTHER'S MAIDEN NAME <u>Eliza Davidson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT Address <u>Russell C. Watkins- Item # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>350x cerebral anoxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Broncho-pneumonia</u> DUE TO (c) <u>Parkinsonism &amp; generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>3 days</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2/1/53</u> , to <u>5/29/56</u> , that I last saw the deceased alive on <u>5/29/56</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Pumphrey</u> M.D.				ADDRESS (Street, city or town, state) <u>Bethesda, Md.</u>			
DATE SIGNED <u>5/31/56</u>				PHYSICIAN'S NAME (Type) <u>Robert A. Pumphrey-Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-2-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Browningsville Ch. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Browningsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>6/1/56</u>		24b. REGISTRAR'S SIGNATURE <u>Laurel Kragtorp</u>	

EC.

BUREAU V. S.

1956 7 JUN

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**5358**  
**CERTIFICATE OF DEATH**

05354

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> <span style="float:right">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>12 days</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>				47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNM, Bethesda, Md.</b>				d. STREET ADDRESS <b>1806 Wyoming Ave., N.W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>Oscar</b>		Middle <b>Jabez</b>		Last <b>WEEKS</b>	
4. DATE OF DEATH		Month <b>May</b>		Day <b>30</b>		Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>30 Sept. 1879</b>		9. AGE (In years last birthday) <b>76</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy (Retired)</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Jabez WEEKS</b>				14. MOTHER'S MAIDEN NAME <b>Sarah DAVIS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW-I &amp; II</b>		17. INFORMANT <b>James E. WEEKS (Brother)</b>		Address <b>Swansboro, N.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Portal vein thrombosis</b> DUE TO <b>Carcinoma of the liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>unknown.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Portal Cirrhosis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>18 May</b> , 19 <b>56</b> , to <b>30 May</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>30 May</b> , 19 <b>56</b> , and that death occurred at <b>11:35 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 5-31-56</b>							
ACTUAL SIGNATURE <b>William I. Freud</b>		M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>					
PHYSICIAN'S NAME (Type) <b>William I. Freud, LT, MC, USNR</b>		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-4-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S.H. HINES Funeral Home, 2901 14th St., N.W.</b>				24a. REC'D BY REGISTRAR <b>DATE 5-31-56</b>		24b. REGISTRAR'S SIGNATURE <b>Mary E. Russell</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 4 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4)  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5359  
CERTIFICATE OF DEATH

05355

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Germantown Md</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Grove Md</u>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>OVID</u> Middle <u>H</u> Last <u>WELLS</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 13 1894</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming own</u>	
11. BIRTHPLACE (State or foreign country) <u>Shedville Tenn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>S. R. Wells</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bowman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217367271</u>	
17. INFORMANT <u>Hattie A Wells</u> Address <u>Germantown Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>420.0</u> DUE TO <u>Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Arteriosclerosis</u> DUE TO <u>Heart Disease</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> , to <u>May 28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 26</u> , 19 <u>56</u> , and that death occurred at <u>8:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jack Schumacher</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>5-29-56</u>	
PHYSICIAN'S NAME (Type) <u>Jack Schumacher</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 31 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Salem</u>		22d. LOCATION (City, town, or county) (State) <u>Cedar Grove Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barber</u> ADDRESS <u>Germantown Md</u>		24a. REC'D BY REGISTRAR DATE <u>June 1/56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Hattie A. Burdette</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 1956

BUREAU V. 2

JUN 4 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 105356  
5360  
CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Montgomery</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Mont.</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00 9401 Thornhill Dr.</b>				STREET ADDRESS (If rural give location) <b>9401 Thornhill Dr.</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>HELEN WESTCOTT</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>May 20 19 56</b>			
5. SEX: <b>F</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Widowed</b>	8. DATE OF BIRTH: <b>APRIL 14, 1874</b>	9. AGE last birthday: <b>81</b> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>AT HOME</b>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>JAMES HASKEL MOSES</b>				14. MOTHER'S MAIDEN NAME: <b>ELIZABETH HITCHCOCK</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <b>HENRY H. WESTCOTT, RANCOCKS WOODS, N.J.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Mucoid carcinoma of the colon with metastases to the liver</b>						1 year	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Arteriosclerotic heart disease with decompensation</b>						1 month	
19A. DATE OF OPERATION: <b>October 15, 1955</b>		19B. MAJOR FINDINGS OF OPERATION: <b>Mucoid carcinoma of ascending colon</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>July 1955</b> , to <b>May 20, 1956</b> that I last saw the deceased alive on <b>May 12, 1956</b> , and that death occurred at <b>3:15 PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>Bennet A. Porter, Jr., M.D.</b>		ADDRESS <b>M. O. 9301 Colesville Rd. Silver Spring, Md.</b>		DATE SIGNED <b>May 20, 1956</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>5/23/1956</b>		NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cem.</b>		LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
DATE REC'D BY LOCAL REGISTRAR <b>5-24-56</b>		REGISTRAR'S SIGNATURE <b>Francis C. Toller</b>		24. FUNERAL DIRECTOR <b>Joseph Deimler Sons, 1756 Pa. Ave., N.W., Wash., D.C.</b>			

BUREAU V. 1

MAY 23 1956

RECEIVED

MEDICAL CERTIFICATION



Levonoville, Mo.

TO HO... OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4  
may be... by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5362

CERTIFICATE OF DEATH

05358

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		d. STREET ADDRESS <u>5901 31st Place, N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Otis</u> Middle <u>(n)</u> Last <u>WILDMAN</u>		4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1890</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy (Retired)</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William A. WILDMAN</u>		14. MOTHER'S MAIDEN NAME <u>Kate KENDRICK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>(Wife) Mrs. Carrie WILDMAN (Same As #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.1</u> DUE TO <u>Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>9 hours</u> <u>15 years (approx)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>14 May</u> , 19 <u>56</u> , to <u>14 May</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>14 May</u> , 19 <u>56</u> , and that death occurred at <u>10:43 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. U.S. Naval Hospital, NMMC, Bethesda, Md.</u> <u>5-15-56</u>			
ACTUAL SIGNATURE <u>Bruce L. Canaga</u> PHYSICIAN'S NAME (Type) <u>Bruce L. CANAGA, CAPT, MC, USN</u> <u>U.S. Naval Hospital, NMMC, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>17 May 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>May 15 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>May 15 1956</u>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

DATE OF DEATH

TIME

PLACE

CAUSE

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

DATE OF BIRTH

(Place) (Sex) (Age) (Race) (Education) (Occupation) (Religion) (Usual Residence) (Date of Birth)

BUREAU V. S.

MAY 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5363

CERTIFICATE OF DEATH

05359

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>20 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1232 - Noyes Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Walter SUMNER Wilson</u>				4. DATE OF DEATH Month Day Year <u>May 15, 1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 25, 1892</u>	
9. AGE (In years, lost birthday) <u>64 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN OF MACHINE OPERATORS PEP CO.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WASHINGTON, D.C.</u>			
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>CHARLES S. WILSON</u>				14. MOTHER'S MAIDEN NAME <u>CORA ECCLESTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW#1</u>				16. SOCIAL SECURITY NO. <u>577-05-0856</u>			
17. INFORMANT <u>MRS. GERTRUDE WILSON, 1232 NOYES DRIVE</u>				Address <u>SILVER SPRING, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute Myocardial Infarction, Immediate</u> DUE TO (b) <u>Acute Coronary Artery Thrombosis</u> DUE TO (c) <u>Coronary Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1948</u> to <u>May 15, 1956</u> , that I last saw the deceased alive on <u>May 14, 1956</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James W. Long</u>				DATE SIGNED <u>9-15-1956</u>			
PHYSICIAN'S NAME (Type) <u>JAMES W. LONG</u>				ADDRESS (Street, city or town, state) <u>915 19th St., N.W., Washington, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>5/22/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05360

## 5364 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Montgomery</u></span>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b  			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7127 Braeburn Place</u>				d. STREET ADDRESS <u>7127 Braeburn Place</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>LEO</u> Middle <u>A</u> Last <u>WOLFSOHN</u>				<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>24</u> , Year <u>19 56</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 4, 1890</u>		9. AGE (In years last birthday) <u>66</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov't. Emp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Jacob M. Wolfsohn</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Bornstein</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.  		17. INFORMANT <u>Joel Wolfsohn-Item # 2</u>				Address  	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <u>5-25-56</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>5-27-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>National Mem. Park</u>			22d. LOCATION (City, town, or county) (State) <u>Falls Church Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>					ADDRESS <u>Washington, D.C.</u>				
24a. REC'D BY REGISTRAR <u>DATE 5-28-56</u>			24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>						

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any date necessary, please execute the date, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED

5365

CERTIFICATE OF DEATH

05361

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4522 Middleton Lane</b>		d. STREET ADDRESS <b>4522 Middleton Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Hall</b> Last <b>YOUNG</b>		4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 30, 1874</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>14</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Patent Attorney</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Nicholas E. Young</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Cross</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>WWI</b> <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Fanny Hempstone Young-Same Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestive heart failure</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>hypertensive heart disease</b> DUE TO (c) <b>hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September, 1953</b> , to <b>13 May</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>13 May</b> , 19 <b>56</b> , and that death occurred at <b>4:55 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>7659 Georgetown Road, 14 May 56</b>			
ACTUAL SIGNATURE <b>John M. Wyman</b>		M.D. <b>7659 Georgetown Road, 14 May 56</b>	
PHYSICIAN'S NAME (Type) <b>John M. Wyman</b>		<b>Bethesda 14 Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/16/1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-7557 Wis. Ave. Bethesda</b>		24a. REC'D BY REGISTRAR <b>DATE 5-16-56</b>	24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		MAY 14 1968	
AGE		SEX	
35		Male	
RACE		EDUCATION	
White		High School	
OCCUPATION		PLACE OF BIRTH	
Attorney		Memphis, Tennessee	
CAUSE OF DEATH		MANNER OF DEATH	
Suicide		Accident	
DETAILS OF DEATH		SIGNATURE OF PHYSICIAN	
James Earl Ray was found in his apartment in London, England, on May 14, 1968, with a self-inflicted gunshot wound to the chest. He was pronounced dead at the scene.		[Signature]	
CERTIFICATE OF DEATH		FILING OFFICE	
[Signature]		[Signature]	

BUREAU V. S.

MAY 21 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05362

5366

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Henrico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN lb <b>302 das.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Richmond</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b> <b>National Institutes of Health, Bethesda</b>				d. STREET ADDRESS <b>2000 Southcliffe Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lee</b>		First <b>Lee</b> Middle <b>Hammer</b> Last <b>Zirkle</b>		4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>14 February 1910</b>	
				9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
						12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles A. Hammer</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Loewner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>The Medical Record, Clinical Center, NIH.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Perforation of ascending colon + massive</b> <b>170X</b> DUE TO <b>metastatic carcinoma of breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>g-3 hemorrhage</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>26-48 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 5, 1955</b> , to <b>May 2, 1956</b> , that I last saw the deceased alive on <b>May 2, 1956</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Arthur G. Ship</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>		DATE SIGNED <b>5-2-56</b>	
PHYSICIAN'S NAME (Type) <b>Arthur G. Ship, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 2, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Richmond, Va</b>		22d. LOCATION (City, town, or county) (State) <b>Richmond, Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Patterson</b>				ADDRESS <b>3619-14 NW NW</b> <b>Washington DC</b>		24a. REC'D BY REGISTRAR DATE <b>5/3/56</b>	
						24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	



CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
Charles A. Brown		Male		35		1920		Baltimore		Maryland		Baltimore		Maryland	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
Teacher		Heart Disease		Natural		1955		Baltimore		Maryland		Baltimore		Maryland	
FAMILY HISTORY		PREVIOUS ILLNESS		TREATMENT		BURIAL		FUNERAL		CITY		COUNTY		STATE	
None		None		None		None		None		None		None		None	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER	

BUREAU V. 3

MAY 7 1956

RECEIVED